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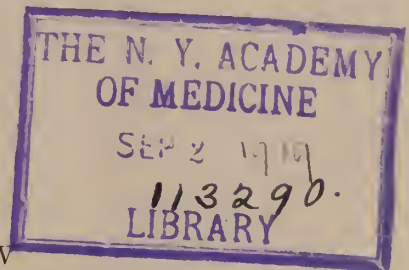
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INDEX TO VOLUME XXXV

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INDEX TO VOLUME XXXV

January to June, 1919

This is an alphabetical index of articles and discussions arranged by leading words. It contains occasional cross references. Names of authors and men who discussed the papers, are also included. Details of society proceedings, including the names of papers read, officers elected, etc., can

be located in the proceedings under Societies. Editorials, News of the State, Marriages, Deaths, Public Health items are classified under these headings. The subjects of editorials and public health items also appear alphabetically and are marked (E) and (PH).

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No. 1

Original Articles

HEALTH INSURANCE*

CHAS. J. WHALEN, M. D.
CHICAGO.

Health insurance in my estimation is a Kultured Beast of Prey clothed in the garb of philanthropy. Compulsory health insurance received its prime impulse from Bismarck. Born of the Kulturkampf, it was devised to meet the discontent due to long hours and low wages prevalent in the larger cities of Germany. Its paternalistic provisions have so dulled the sensibilities of the German people and destroyed initiative and self-reliance as to facilitate the growth of Autocracy and caste control. It has accomplished the object of the Iron Chancellor.

The word compulsion has an ugly sound to Americans: it suggests the click of handcuffs, it smacks of the inquisition and all that goes with it. To thinking men the whole propaganda should suggest the mailed fist, in the velvet glove, From every standpoint except the political, it is a vicious delusion.

These momentous words "If the forces of autocracy can divide us they will overcome us" was recently sent by the President of the United States to a European nation, and almost simultaneously in this country a group of men who should stand for all that is sound, high and noble were formulating sentiments favorable to the establishment of an autocratic form of government among us. This is a sad commentary on Americanism.

This group of men known to us as social reformers are calling for state provided sickness insurance and are now urging the Mills Bill

introduced in the New York Legislature in 1916 and to be introduced again this year.

The proposed plan for Compulsory Health Insurance would produce "a superlative Prussianism, a condition of society in which the individual shall be submerged in the state for the purpose of being made a superman," and has "so magnified the idea of Nietzsche as to cast that German madman into the discard. Such a development would blot individualism, democracy and freedom off the habitable earth."

More Germans die or lose time by sickness, under Health Insurance, than Americans.

Not only do the wage-earners of Germany and Austria lose more time through sickness under Compulsory Health Insurance laws than in the United States without such laws, but it also is interesting to note that it has produced in the habits of German and Austrian workers a tendency to become sick, to imagine they are sick or to make believe they are sick. The figures are illuminating. In Germany out of every 100 insured wage-earners, 36.7 were listed as sick in 1890, and 45.6 in 1913; in Austria the corresponding figures were 45.7 in 1890, and 51.8 in 1913. In Germany the average number of days of sickness for each sick member increased from 16.2 in 1890 to 20.2 in 1913, and in Austria from 16.4 in 1890 to 17.4 in 1913. The average number of days of sickness per insured member, which was 5.9 in Germany in 1885, when the law had just gone into effect, increased to 6.19 in 1890, and 9.19 in 1913, while the Austrian statistics from 1890 to 1913 show an increase from 7.98 to 9.45 days. Not only did the duration of sickness per person increase, but more persons were reported sick in Germany and Austria in 1913 than in 1890, showing that Compulsory Health Insurance laws did not prevent sickness nor minimize its duration, and, therefore, did not promote efficiency.

Lower Death Rate in the United States.

In 1912 the death rate in Germany was 15.6 per thousand population, in Austria, 20.5, and in Hungary, 23.3. Now compare these figures with the mortality rates in several countries which had no compulsory health insurance laws in effect. In the same year the death rate in Australia was 11.2; in New Zealand, 8.9; in Sweden, 14.2; in Switzerland, 14.1; in Belgium, 14.8; in Denmark, 13; in the Netherlands, 12.3, and in the United States, 13.9, which was further reduced in 1915 to 13.5.

*Arguments against Compulsory Health Insurance presented by the joint committees of the Illinois State Medical Society and the Chicago Medical Society before the Illinois State Legislature Health Insurance Commission at Chicago, November 8, 1918.

Arguments by Drs. Whalen, Ochsner and Ballinger representing the committees named and Dr. M. L. Harris at the invitation of the Commission.

This low rate was obtained in spite of the fact that the ordinary tendency to disease is aggravated by a great variety of climates in the United States, by diversity of races represented in our population and the fact that the United States has kept its doors open to millions of immigrants unused to our change of climate, many of them physically wasted by toil and privations in their homeland.

ESTIMATED COST OF COMPULSORY HEALTH INSURANCE IN ILLINOIS

WHO AND WHAT WOULD BE INVOLVED

Using the Nicoll Bill (N. Y.) as the basis for computation.

1. Population of Illinois.....	5,500,000
2. Number that would be subject to law, 85 per cent. (Art. 1, page 3).....	4,675,000
3. Number disabled each year by sickness and accidents not covered by compensation laws, 33 per cent. of No. 2.....	1,558,000
4. Number that would require nursing, 25 per cent. of No. 3.....	389,500
5. Number that would require hospital care, 16 $\frac{2}{3}$ per cent. of No. 3.....	259,600
6. Number that would require operations, 8 $\frac{1}{3}$ per cent. of No. 3.....	130,000
7. Number of visits from physicians, figuring average disability of 21 days, 15 times No. 3.....	23,370,000
8.	
9. Number of Carrier Associations necessary to administer the law, allowing 4,000 wage earners and 5,000 dependents for each.....	520
10. Number of officers, directors and employees necessary for 520 associations, 25 each.....	13,000
11. Number of State and City employees coming under the law, to be paid for by tax payers.....	140,000
12. Number of days to be compensated to wage earners, 7 each.....	16,800,000
13. Funeral benefits, based on American Life Tables, average of deaths per 1,000 per year among wage earners 16 to 60 years of age 14.7. 14.7 per 1,000 = 14,700 per 1,000,000 \times 2 4/10. Deaths annually.....	35,280
14. Necessary expense to maintain 600 laboratories annually, each.....	\$1,000
15. Cost of medical and surgical supplies No. 3 \times \$2.00 each.....	
16. State supervision and administrative expense. Political—put in your own figures. Ohio employs some 800 politicians to administer its compensation benefits to $\frac{1}{4}$ the number of people and only $\frac{1}{8}$ as many claims.....	
17. Dental service No. 3 \times \$5.00 each....	
18. Reserves 5 per cent. of cost.....	

COSTS

The marginal reference numbers refer to the corresponding numbers, above.

Figured on
Economic Society
Basis

4. 389,500 patients \times 15 @ \$2.25 per day	\$13,146,000
5. 259,600 patients \times 12 days @ \$15.00 per week.....	6,676,000
6. 130,000 patients \times \$20.00 each....	2,600,000
7. 23,370,000 visits @ 25c each.....	5,843,000
9. 520 Carrier Associations @ \$15,000 each per year.....	7,800,000
11. 140,000 \times \$15.00 each ($\frac{1}{2}$ of whole cost)	2,100,000
12. 16,800,000 at average of \$1.00....	16,800,000
13. 35,280 at \$100 each.....	3,528,000
14. 600 at \$1,000 each.....	600,000
15. 1,558,000 at \$2.00 each.....	3,116,000
17. 1,558,000 at \$5.00 each.....	7,790,000
18. Add 5 per cent. of Nos. 4-17 inclusive	3,500,000

Total\$73,499,000

Numbers 4, 5 and 6 are figured at less than $\frac{1}{2}$ the number of patients given in questionnaire replies.

No cost was asked of physicians regarding No. 7. No. 17. Figures furnished by dental societies and dentists.

FIGURES ARE CONSERVATIVE

The figures herein presented were compiled with extreme conservatism and some of them are ridiculously low, such as doctors' visits at 25c each and trained nurses at \$2.25 per day.

Every total shown will prove to be less than reasonable cost under present conditions.

It would require

20,000 more trained nurses,
5,000 more dentists,
\$80,000,000 more in hospitals to equip the state of Illinois for this service.

At \$24.00 per capita per year, which is the lowest estimate yet made, the total annual cost for the nation for sickness insurance alone would amount to about \$1,080,000,000.

A program calling for any such expenditure would in any case challenge critical examination and compel convincing demonstration of its merit. This evidence is not to be found in the experience of foreign countries where sickness insurance has been tried and where on the one hand it has failed as a preventive agency and on the other hand has placed a premium on inefficiency and fraud. But even if it had worked advantageously in those countries the wisdom of its transfer to the United States where social and political con-

ditions are so radically different would not necessarily follow.

Conditions in America are not such as to warrant this huge expenditure. We have the blessings which come from an individualistic system, from a freedom of action and initiative, from a broad opportunity to work and achieve. Shall we give up all of these things and depend upon the government as an indulgent parent, to shoulder our burdens, rather than rely upon our own brains, our own strength, our own initiative, our own opportunity?

Prevention is the antithesis of compulsory health insurance. It has often been claimed that a sickness insurance system creates an incentive for preventive work. The experience of the European countries does not support this contention. Indeed, it is difficult to see any logical ground for the claim; a clear appreciation of the extent of sickness and disability and the heavy burden which they place upon society should be the sufficient and powerful incentive for prevention. Insurance is not the solution of the problem. If interest in prevention can be aroused through an insurance system, it should be much more sharply stimulated by an organized program having prevention for its chief object.

The incentive for a community to spend large sums in preventive work is not increased by first draining its resources to support an expensive system of treatment and insurance.

If the wage-earner, instead of being compensated over a period of two, ten, or twenty-six weeks to the extent of two-thirds of his wages, can be saved the disability and consequent loss of time by one-half of this outlay, or even by an equal expenditure, it is clear not only that he is himself directly benefited but also that society as a whole secures an advantage; because, by prevention the loss of production which would result if his disability were permitted to run into serious incapacitation is averted.

Underlying these considerations is the fundamental fact that all sickness and disability which can reasonably be prevented should be prevented instead of being allowed to remain unremedied until they impose a burden of misery and poverty on the individual and a burden of cost on society.

Finally I wish to emphasize that health insurance will not decrease poverty, but on the contrary will increase it, by creating a larger dependent class, due to the inability of a larger

percentage of our population to obtain work, because of the fact that the employer in order to keep his assessments low will carefully choose his employees, excluding by medical examination all who are not physically perfect, and the discard from these examinations will increase our already permanent pauper class.

COMPULSORY HEALTH INSURANCE*

EDWARD H. OCHSNER, M. D.

CHICAGO.

Mr. Chairman and Members of the Commission: The two phases of this problem that interest me particularly, and the two phases that I will speak on principally, are, the effect upon medical progress and the effect upon the quality of medical services of compulsory health insurance. Now, we have some data upon which we can go. The experience of the European countries which have tried compulsory health insurance for thirty-five years or more are of a good deal of value in discussing these two phases of the problem. I have written out with considerable care two postulates:

"Next to stability of government, honesty of administration, and general intelligence of the people, the welfare of a nation depends more upon the quality of medical service which is rendered to the people, than upon any one other thing.

"The longevity, health, efficiency and happiness of a people depend more upon the integrity, ability and industry of its medical profession than upon anything else.

"If it can be demonstrated that compulsory health insurance has lowered the standard of medical service where it has been in force the longest, and is likely to have that effect if introduced in this country, then surely it would be unwise to introduce it here."

I think every thinking man and woman will agree with me that these two primary postulates and the secondary postulate are absolutely true. If we can prove that in European countries medical progress has been seriously checked by compulsory health insurance; if we can prove that the quality of medical service rendered under compulsory health insurance is poorer in those countries, then compulsory health insurance has

*Argument presented before the Illinois State Health Insurance Commission, at Chicago, Illinois, on November 8, 1918.

not even one leg to stand on, gentlemen, and I believe we can prove just that.

From the year 1860 to the beginning of this century, Germany and Austria were in the forefront of medical progress. Everyone, even the layman, is familiar with such names as Billroth, Volkmann, Hebra, Koenig. Billroth was the great German surgeon who finally went to Austria, and who did the great primary work in stomach surgery; Volkmann was the great bone surgeon; Hebra was the great skin specialist, and Koenig was another great bone surgeon. In the early seventies and eighties, fractures and such things were about the only things surgeons attended to. Modern surgical technique had not made the other work possible. I could mention to you, gentlemen, thirty or forty other German and Austrian medical men who ranked almost as high as those mentioned. Behring and Roux, the Frenchmen, simultaneously, in 1894, discovered the diphtheria serum. Roentgen, a German, discovered the Roentgen Rays, the X-Ray, as we speak of it, in 1895. Lorenz, the Austrian surgeon, introduced the bloodless cure for congenital dislocation of the hip, in 1896. Isn't it a strange thing, Ladies and Gentlemen, that since 1896 not one single thing of prime medical importance has come out of Germany and Austria? One. I beg your pardon. Salvarsan, and that was a laboratory discovery. It was discovered by a man who knew absolutely nothing about the practice of medicine; a graduate in medicine, yes, but he never practiced a day. Let me tell you a little story about the man who discovered salvarsan. In 1904, I studied in Germany, and a very intimate friend of mine was studying under this particular man. One morning my friend was in the laboratory and the professor came in and he said "Diener." Well, the "Diener" knew what that meant. It meant his laboratory coat and his slippers, and then he again said, "Diener," and the diener knew what that meant. That meant a match, and the great professor pulled out a cigar. My friend was startled by its size. The professor noticing his surprise said, "You seem to be surprised at my cigar." It was one of unusual length, in fact, at least three times the ordinary size. He said, "My doctor has examined my heart and he says I must not smoke more than three cigars a day, consequently, I have had these made specially." That is the kind of a doctor he was, gen-

tleman, and yet, he discovered the only thing of importance that has come out of Germany in the last twenty years. Why? Because compulsory health insurance has crushed the independence and enthusiasm out of the German profession to such a degree that men of real ability are studying medicine in smaller and smaller numbers in Germany today, and the men of the first magnitude in Germany and Austria today under forty years of age can be counted on the fingers of one hand, among one hundred and thirty million people. There is a reason for that, gentlemen.

In the meantime, ladies and gentlemen, what has happened in America, and in the countries which have not been cursed by compulsory health insurance until recent years? Let me tell you a few of the things that have been accomplished in the last twenty-five years outside of Germany and Austria. Germany and Austria, who were the leaders in the science of medicine twenty-five years ago, have taken a place way down. There is a reason. If anybody else can give us another reason than the one I have mentioned, I would like to hear it.

In America and other countries progress has been steady, Appendicitis and its treatment was developed principally in Chicago, Philadelphia and New York; gall bladder surgery in Rochester, Minnesota and Chicago; goiter surgery in Berne, Switzerland, Chicago and Rochester; stomach surgery in Rochester and Leeds, England; malaria and yellow fever by our own Walter Reed of the Marine Hospital; joint surgery in Boston, New York and Chicago. Why do not Germany and Austria come in for a little of that? Now, those are medical facts, and they cannot be successfully disputed because they are facts. When Billroth died, along in 1892 or 1893, all progress in stomach surgery stopped until Drs. William J. and Charles H. Mayo revived it and brought it up to its present degree of perfection. Why did not the followers of Billroth do that work? They had the advantage of being his assistants for years. Why?

Now then, the quality of medical services. Not only has medical progress been almost killed by compulsory health insurance legislation in Germany and Austria, but the quality of medical service which the people of those countries receive has deteriorated immeasurably in the last thirty years. Why? Why should it, gentlemen? If you

overwork and underpay a medical man, his quality of service is going to degenerate, deteriorate. Now, it may be said, it is not necessary to overwork or underpay him. Pay him enough, and don't overwork him, and his quality of medical service will remain the same. That sounds good, but it will not work out practically. First of all, the number of calls increase so terrifically under compulsory health insurance that you cannot pay him enough. There is not enough money to pay him. How do I know that to be a fact? You ask any man who has been in contract practice for twenty years what per cent of his calls are unnecessary, and he will tell you more than half. I have interviewed twenty or thirty men engaged in contract practice in the last twenty years. I have been interested in this problem for over twenty years. I have interviewed twenty or thirty prominent men, prominent in contract practice, and I have asked them, "What is the peculiarity of your practice? Why do so many of you leave contract practice just as quickly as you can?" "Oh, we are pestered to death by unnecessary calls." One will tell you, "I make two calls where I should make only one." Another will tell you, "I have to make three calls where I should make only one." And another will tell you, "I make four calls where I should make only one." A man with enthusiasm will not chase around and make unnecessary calls. He will quit contract practice and go into private practice, and that is what is happening all the time. Men of real ability do not often stay in contract practice very long, principally for that reason. They are underpaid and overworked, and the enthusiasm is crushed out of them. The same thing holds true in lodge practice. Enormous numbers of unnecessary calls are made, and there is one shining example of the abuse of this practice for which I have absolutely reliable statistics. Four or five or six years ago, I cannot give you the exact date, the University of Wisconsin went into a combination of welfare and contract practice. They charged their students so much per semester and they appointed a medical staff to look after their health and to treat them. In the winter of 1916, I was asked to appear before the Committee on Education of the Legislature of Wisconsin, and in the presence of that Committee and within my hearing the Dean of the Medical School of the University of Wisconsin made the statement that during the

fall semester of 1915-1916, a period of four months, the clinical staff of that University made seventeen thousand examinations and calls on between four and five thousand students, healthy young men and women in the prime of life, or at the rate of about thirteen plus per year. They are figures that you cannot go back of, and they prove that when a man or a woman can have free medical advice they are running to the doctor for every little ache and pain and they wear out his enthusiasm, and men of ability will not practice that kind of medicine very long. And when they once find out that that is the kind of practice of medicine they will have to go into, they will not study medicine, and that is just what happened in Germany and Austria. The quality of the average German and Austrian medical man has so deteriorated that, in answer to Mr. Ransom's question I will say, yes, the loss of time from sickness and the increased mortality rate in Germany over Switzerland is because the people of Germany get so much poorer medical service, and it is directly traceable to the compulsory health insurance laws of Germany.

In further support of my statement that compulsory health insurance results either in overwork, underpay, or poorer service, or all three of them, usually all three of them, I can give you a little personal experience, and that is why I have been interested in compulsory health insurance for a period of twenty-two years.

In the summer of 1896 I served as an assistant to a panel physician in the city of Leipzig in an ambulatory clinic for nose, throat, and ear, and I had a splendid opportunity to see the working of the system, and I came to the conclusion, a conclusion which I have seen no reason to alter, that compulsory health insurance must, from the very nature of things, result in overworking the physician, underpay to the physician, or poor service to the people, or any two or three of them.

In the winter of 1904 and 1905, I spent six months doing post graduate work in Berlin. One cold blustery January afternoon I was visiting Professor Schleich's Health Insurance Clinic. About a quarter past two his second assistant breezed into the room, and said in his peculiar Berliner vernacular about the following, "That tin Lizzie of mine is some girl. I started out at nine o'clock this morning to make health insur-

ance calls. I had a lot of time for a good dinner, and between nine and two I made twenty-three calls." That tin Lizzie was some girl. It was before the days when we had self-starters. Now, gentlemen, figure out how much time he had for each one of those calls. Take off half an hour for lunch. That would not be enough, for he took at least an hour, but we will be liberal. We will leave him four and a half hours for making those twenty-three calls. He got out of his machine, walked to the house, opened the door, went into the room, took off his overcoat, because no German doctor would think of examining a patient with it on, questioned the patient, examined the patient, prescribed medicine, went back to the street, cranked his car, got into it, and did that twenty-three times in four and a half hours. How much time did he have for his patients? I will let you figure it out. It was a cold, blustering January day, and this was on the narrow streets of Berlin, with a good deal of snow on the ground. How much were those calls worth? He got twenty-four cents for each one of them. They were not worth it, at least, I don't think they were.

See what has happened to England, Brend, in his book, says that practically no one aside from the panel doctor is satisfied with the working of the English law. The German law was a practical failure. The English is worse. It fails to provide competent care for those needing it. Some investigations showed that for making diagnosis, writing prescriptions—that is what Dr. Whalen referred to, and making records—there are lots of records in health insurance, because they want lots of them, they are strong on records, a panel doctor averaged three and one-quarter minutes per patient.

Is that the kind of medical service we want to give eighty per cent of the people of Illinois? One of your members, I do not see her here this evening, some ten years ago read one of the most scathing papers before the Chicago Medical Society, condemning the treatment that the poor of Chicago got in dispensaries everywhere, and her scathing remarks were justified. The next day I wrote her a letter complimenting her on the paper. Now, do we want the workingmen of America, of this State, to have the kind of medical service that the workingmen of England are getting and the workingmen of Germany are getting? I don't think so, ladies and gentlemen. I

believe we know something about the needs of the workingmen.

I started out as a young man and left home at the age of seventeen with \$1.70 in my pocket and one of those dollar paper satchels. I worked as a farmhand and as a lumber jack and as bookkeeper and as a country school teacher and I think I know a little something about the attitude and the point of view of the American laboring man. I have treated hundreds and thousands of them, and I have made it a point to keep in touch with them. I would rather treat an American laboring man today than anybody else. When I grasp his horny hand I know he is not a parasite, and I do not want, and you do not want, the American laboring man to have that kind of medical service, and he will get it if you give him compulsory health insurance. I believe that the American laboring man wants to have an opportunity to work out his own salvation. I don't believe he wants "von oben herunter." I do not believe he wants things from above down. I think he wants a chance to choose his medical service just like anybody else, and I think to introduce compulsory health insurance would be one of the most vicious things that could be done in this country today.

Permit me, gentlemen, to make the last point that I want to make this evening with a little story. It is a true story. About a hundred years ago there was born of poor but cultured people in Switzerland the first boy. Later a number of other children came. More children, in fact, than the parents could well support. This boy was brought up very largely on potatoes, not much butter and not much gravy with them, and after he had finished the common school and the high school and the normal school and taught school a year or two he decided to emigrate to America and he located in the wilds of Wisconsin. Frugality and hard work brought competence and brought wealth, and as he got older he could not look a naked spud in the face without blushing, he had had so many of them in his childhood. He worked out a very elaborate recipe for his good wife directing how to prepare potatoes, and I heard him give the recipe once. There were six in his family and I remember one evening sitting at his table when I was a boy. He said, that in order to eat potatoes at all they had to be dressed up in the latest Paris style, and he said, "For a family of six you want to take twelve smooth,

medium sized potatoes, wash them in clean water, then wash them again with a brush, then peel them with a sharp knife and be very careful to cut off all the eyes; then grate them on a grating iron, then take a skillet and fill it one-third full of leaf lard and get it boiling hot, and be sure to have it real hot, drop into it twelve perfectly fresh eggs, serve them hot and *put the potatoes in the garbage can.*" Now, gentlemen, if I may be permitted a suggestion, I would make that suggestion about the bill of the American Labor Association. I would first cut out the Enabling Act. I would then strike out two-thirds wages for twenty-six weeks, then free medical and surgical service, then free nursing attendance, then free medical and surgical supplies, then free hospital benefits, then money benefits, then free dental service, then free service for dependents, and *I would substitute therefore the most perfect health law that can be devised.* I would have it introduced in the next Legislature and ask the Legislature to appropriate five per cent of the money required for health insurance, and if you do that Illinois will take a tremendous step forward in social progress, instead of a long step backwards. I thank you.

DISCUSSION.

MR. RANSOM: I would like to ask Dr. Ochsner just one question: In considering the health insurance program there are two particular aspects of it which are quite separate from each other: One, is the medical service and the other is a cash benefit. Do you find objection to the latter?

DR. OCHSNER: Yes, I find serious objection to the latter for the reason that it will increase malingering fearfully. I have not been able to go into all of the things, but I remember very well in 1896, just about twenty-two years ago, I was an externe in an institution in Hamburg, and one morning I was making rounds with Professor Kuemmel, and he had two or three men whom he had to examine after he had examined the first one. He said to me, "Why, there is nothing the matter with that man." The next one he came to he said, "There is nothing the matter with that man." And he turned to me in disgust and he said, "I am wasting,"—I don't remember how much of his time, but he was wasting, say a quarter of his time in ferreting out these malingerers. That is the trouble with it, and malingering increases terrifically, and the honest workman, who is too honest to take anything that does not belong to him, has to pay tribute to the dishonest; and that is the objection that I have to cash benefits.

THE CHAIRMAN: That would not apply, Doctor, of course, to the death benefit?

DR. OCHSNER: That would not apply to the death benefit, no.

THE CHAIRMAN: Of course, the malingering phase of it would not. That is an objection to cash payment.

DR. OCHSNER: This cash payment, yes, two-thirds wages.

MR. WEBSTER: While you were there did you notice any tendency on the part of the people to sort of blacklist, so to speak, a doctor who would not endorse their claims, when he thought they were malingering?

DR. OCHSNER: Yes, that is a very serious business. If you are a panel physician and do not give in to a considerable per cent of that, you do not get your panel full next year. That is the trouble.

MR. WEBSTER: I have understood that to be true, but I thought I would like to know it and have it verified, if it was true, by somebody who had been there.

DR. COOLLEY: Dr. Ochsner, isn't it a fact that your malingerer further injures the man who is really sick by the time he takes away from the physician? Is it not a fact that many malingerers tend to interfere with careful examinations, so that the real invalid is in danger of being overlooked?

DR. OCHSNER: The malingerer actually takes more time than the sick man, because it is an unusually hard problem to detect him. He wastes the time of the doctor. Another thing: If a patient comes to a private physician, that alone is a presumption that he is sick, while the panel physician is always under the impression that he is just putting it on.

DR. COOLLEY: That is my question. He assumes that he is not sick.

DR. OCHSNER: That is the point.

MR. WEBSTER: Because there is so much malingering.

DR. OCHSNER: Yes. That is the point. In every department of medicine in Germany there are books that are inches thick telling you just exactly how to detect the malingerers. Now that would not be true if there was not much of it. We haven't that in our medical literature here in America. A little has grown up recently during the draft examinations, but there is so little of it in private practice that we haven't these text-books here in America.

THE CHAIRMAN: Doctor, what has been your experience—you have indicated that you have had a large practice amongst laboring men, as to the effect of the reluctance of the man who is out of funds and therefore cannot pay for the assistance of doctors, in delaying the time of going for medical attention?

DR. OCHSNER: There is, of course, a little of that, but a very little, and here is the peculiar thing: That the man who has no funds to go to a doctor won't be covered by any law that you can devise. The pauper cannot be covered; the occasional worker will not be covered. The steady worker has the means to pay.

THE CHAIRMAN: Well, take the case, Doctor, of which there seems to be evidence of considerable number, where the wage is just sufficient to support the

family in the ordinary mode of living. The instance of sickness comes or, if you please, the man is not sick enough to be compelled to leave his work by reason thereof, but if he had the cash benefits and the opportunity for medical attention under such a system, would cease work until such time as he did have the proper medical attention and recover. Now, under the present system it is contended that in those families the wage earner continues at work because at first he cannot afford to give up his day's wage, and secondly he has not the money to pay for what he knows is going to be an expensive thing, to wit, medical attention. What is your experience in that regard?

DR. OCHSNER: I do not believe that cuts so much figure, as is generally supposed. Doctors always give credit, and a man who bears a good reputation in his community can always get a medical man to look after him. Now that thing sounds mighty good, but if going earlier to the doctor prevented sickness and death, surely the number of days lost by the German workingman and the mortality, in other words, the morbidity and the mortality should not have increased with compulsory health insurance as they have. They have actually increased in Germany and they are higher than they are here, where we haven't got it. That one thing, I believe, should sweep away all of the theoretical contentions of that kind.

THE CHAIRMAN: Well, would it necessarily follow that because those figures are higher in Germany than here, that it is explained by what you indicate? May it not be that we are far more advanced in general matters of sickness prevention and disease prevention than they are there?

DR. OCHSNER: Well, if you want to say that, compare it with other countries around it. Compare it with Belgium, Denmark and Switzerland. Here is a peculiar thing. Why has the best governed country in the world, Switzerland—and I don't believe there is any question about that statement—why has the best governed country in the world, surrounded by all these countries that have adopted it, not adopted the compulsory health insurance? That is a very pertinent question, gentlemen.

MR. MILLIS: Hasn't it recently been adopted in a part of the country? That is my information, that it has.

DR. OCHSNER: I am mighty sure that it is not compulsory.

MR. MILLIS: Yes, I understand it is in effect in a good many places. At least, it is so reported.

DR. OCHSNER: I do not believe it is compulsory. It may be voluntary, and that is a different proposition.

THE CHAIRMAN: Is Switzerland considered to be an industrial country, as we understand that phrase, with large centers of urban population of an industrial character?

DR. OCHSNER: Well, it depends a good deal upon what you mean by industry. Zurich is a big city, three hundred thousand, I believe, it was nearly that when I was there, and you know that Switzerland does not

begin to raise enough food. Almost everybody works in a factory in Switzerland, or works on piece work in his own home. There is no country in the world where, I believe, that same thing is true, and there is no country in the world where so large a per cent of the population is engaged either in factory work or piece work in the homes, as in Switzerland, and I would say it was one of the most highly specialized industrial countries in the world.

MR. MILLIS: Is it true the death rate has increased in Germany? I thought there had been a decrease in the death rate in Germany. I understood you to say that there had been an increase in the death rate and also the sickness rate?

DR. OCHSNER: No, I said this: That the number of days lost by the German worker due to sickness has actually increased in Germany and that the mortality is higher than in the surrounding states.

MR. MILLIS: But the death rate has decreased?

DR. OCHSNER: Oh, yes, it has in every civilized country in the world.

MR. MILLIS: To what extent would the changes in the law, made from one time to another, affect the number of cases per hundred, and the average duration? Of course, that law has been changing. It was one thing in the earlier years and finally they made it much more extensive and more liberal in 1911; that is, they started off with thirteen weeks' limitation on the benefits, then they made it twenty-six weeks, and some of those morbidity statistics are based on the records of those societies. Would the changes in the law be one factor to take into consideration in making use of those figures? That is, if the law is more liberal, if the service extended for twenty-six weeks instead of thirteen weeks, then, of course, your average is increased, and if the wage period is reduced from seven days to three days, then the number of cases of sickness per hundred would increase.

DR. OCHSNER: Yes, but I don't think the number of days of sickness would have any relation to that, because the days of sickness are counted from the first day, and the number of days per annum per worker would not be affected by that case in the law. The amount of money paid would, and the amount of sick benefits would, but the number of days' sickness would not be affected at all by those laws, because the first day of sickness has to be reported, whether he draws benefit on the third day or the seventh day.

MR. MILLIS: I find it a source of difficulty in making comparisons because of the difference in the wage periods, and the number of consecutive weeks for which the figures can be carried, because the morbidity figures are incidental to this.

DR. OCHSNER: I do not think that that would affect the morbidity figures at all. It would affect the benefits.

MR. MILLIS: The German official reports give that explanation, of course, in connection with those tables.

DR. OCHSNER: That is one very interesting thing. If you simply follow the German official reports, it is all fine, it is lovely; but, if you do as I did, live with

the people, the story is a very different one. I was, for eighteen months, in different cities in Germany without sleeping one night in a hotel. I lived with the people, all classes of people, and the story I got did not gibe with the story that the officials give out. The officials have got to put the best fact forward.

COMPULSORY HEALTH INSURANCE*

J. R. BALLINGER, M. D.

CHICAGO

The committee on health insurance of the Illinois State Medical Society which represents 101 component county medical societies including the Chicago Medical Society, and we have reason to believe the personal opinion of the overwhelming majority of the practicing physicians in the state, begs leave after a thorough study of the subject for two and one half years, to submit the following objections to public health insurance.

There seem to be so many objections, economic, educational and political, that the committee sees fit to make objections to all of these, and has presented its objections in printed form which have already been widely published not only in this State but in other States interested in the subject.

The committee however believes that more good can be accomplished by the State Health administrative bodies in the prevention of disease, and if they do not now have the power it can easily be secured; this we think is in the province of organized society as represented in the Government.

Certain specified occupational diseases which are well recognized do not need the unreasonable sickness insurance system to administer to them, but may be included in the Compensation Act.

In the consideration of health insurance our first thought should be "Is it a good thing for the wage earner and is it predicated upon necessity?" The demand for this legislation has not come from representatives of labor, whether organized or not, but chiefly from those who are not the representatives of wage earners' interests. It is extremely significant that this movement, which primarily concerns wage earners and their dependents, should be strongly opposed by the American Federation of Labor.

The scheme is un-American. Americanism means that the individual amounts to something: Paternalism that the individual is non-important

but that the state is all important. Even a beneficent paternalism is harmful because it destroys individualism and discourages thrift.

It is not demanded by the employees, the employers, or by the physicians who will be compelled to work under its provisions. On the contrary, the employees, as represented by organized labor, the employers, as represented by the National Association of Manufacturers, the Real Estate Owners Association, the New York Chamber of Commerce, the Board of Trade & Transportation, and others—a combination of both employees and employers, as represented by the National Civic Federation; the physicians, as represented by the largest and about 100 other county medical societies in the State of Illinois; the New York Medical Society, and even the Social Insurance Commission of the State of Massachusetts have all gone on record as being squarely in opposition to the "Standard Bill."

Only a very small part of the population is without needed medical care, and we deny that any worthy individual is suffering from the want of medical care—so-called surveys made by medically unqualified (therefore incompetent persons) to the contrary notwithstanding.

Compulsory health insurance for workers is based upon the theory that they are unable to look after their own interests and the state must interpose its authority and wisdom and assume the relationship of parent and guardian. There is something in the very suggestion of their relationship and this policy that is repugnant to free-born citizens because it is at variance with our concepts of voluntary institutions and individual freedom. To compel a citizen against his will to enter any insurance contract and impose upon him the burden of paying the premium in whole or in part is un-American and dangerous to civil liberty.

The argument that "poverty is the cause of sickness and not sickness the cause of poverty," as many of our economists would lead us to believe, is not true, and the mere makeshift of paying a small indemnity in case of illness, and "broking" the medical service—which would tend to do away with competition in the profession—would only add to the condition of poverty by shifting the burden of paying a living wage and giving steady employment from the place where it belongs.

According to the report of the Fabian Society of the City of London the fundamental needs of the poor are essentially want of sufficient wage, want of nourishment, want of warm clothing, want of decent housing, and want of rest.

No health insurance legislation should be enacted before we rectify the unfairness of the present Compensation Law. State insurance for accident compensation should be tried out before we attempt to enact such laws.

It would be a barrier for the boys returning from the front, it would be unpatriotic to pass any legislation that would in any way oppose their best interests, and health insurance would jeopardize the

*Address before the Health Insurance Commission of the State of Illinois, November 8, 1918.

interest of the incapacitated in the matter of securing employment because no firm or carrier would feel justified in employing a risk that would not be profitable to them.

With such a large part of the population joined together into societies or funds for their own pecuniary benefit, as the employes and employers would be under the "Standard Bill," it would be a dangerous thing for the state if they should be united as a political party under an unscrupulous boss. The rest of the state would be compelled to yield to them in everything.

Under all the schemes for compulsory health insurance as yet proposed the persons most needing the insurance will not get it. Those who are out of work, except on account of illness, longer than the extension of one week for each four weeks during the previous 26 weeks of paid-up assessments; those who are unable to get into the voluntary insurance societies because they are unable to pass the medical examination, and those who are not insured because they are unable to get work on account of their age; alcoholism, shiftlessness, general incompetency, or any other disabling condition which prevents them from being employed in times of financial distress or panic—these unfortunate conditions will be magnified manifold.

It would bring about compulsory medical attendance and do away with that personal and confidential relationship between doctor and patient, taking from the sick one that confidence, trust and friendship which is such an important part in the proper treatment of diseases. It is this element which makes the practice of medicine a profession and not a business. It is not wholly the dose of medicine that cures the patient, but success is frequently in a considerable measure due to the confidence the patient has in the family physician. This feeling of confidence, trust and personal relationship between doctor and patient, so essential in promoting restoration to health, should not and must not be disturbed by legislation.

We feel that medicine should not be made to bear the brunt of this new experiment in paternalistic government, nor should we permit such legislation to socialize medicine before the public is ready to adopt a complete socialistic form of government.

Why should the profession be taken from the hands of the physician and a price be put upon his services when it is not the case in any other employment? In fact, the trade unions are making their own wage standards and popular opinion is bearing them out in it. A lay person should have the same right to expect state-provided legal services as he has to demand such medical treatment. If there were a Bureau of Justice established where, in criminal or civil cases, citizens were entitled to the best legal defense at the expense of the tax payer, the legal profession would storm the halls of the legislature until such practice was declared illegal: But the long suffering medical profession,

from a habit of atavistic submission, meekly kneels down to receive any added burdens which official zeal or personal ambition sees fit to impose.

While the employer has a great responsibility for occupational diseases it is unfair to compel him to pay 40 per cent. of the cost of the care and treatment of his employes suffering from sickness due to extrinsic causes when contracted while not at work. The employer's responsibility should only hold during working hours. Venereal diseases and injuries received while committing a misdemeanor or felony should not be held against him.

Honorable Francis Neilson, ex-member of the British Parliament and a student of political economy, speaking before the Chicago Medical Society, January 10, 1917, said that social insurance in England is a dismal failure; that it was copied after the German system and that Germany's system is a failure. He says that one has but to investigate all conditions to prove it.

Under the laws the people are presumably entitled to the best medical service that money can buy, but as a matter of fact, they are getting very inferior service.

NATIONAL HEALTH INSURANCE.*

M. L. HARRIS, M. D.,

CHICAGO.

I ought to apologize perhaps for coming before you, as I knew nothing of this meeting until late this afternoon, when I was asked to come down and say something. I have not formulated categorically my views on this subject, although I have given it considerable thought for many years, and have had to do with the enforcement of compensation acts ever since they went into operation.

The question of national health insurance is purely a sociological problem. It concerns society as a whole, and not a particular class. While it could be impossible to make operative any form of health insurance without the assistance and co-operation of the physician, I wish to leave untouched that side of the case which relates to the physician and his relation, from a personal standpoint, to health insurance, and to speak purely of the sociologic side of it.

There are a great many things which the state can do, using the word state in its ordinary sense, for the benefit of the people. But there is a limit beyond which state control of the activities of the individual cannot go without detriment to the development of the individual. Every

*Address before the Illinois State Health Insurance Commission, at Chicago, Illinois, November 8, 1918.

form of life develops best only when it has an opportunity for all of its functions to come into normal action, and when from environment or other condition it becomes necessary for any form of life to take on a special line of development, that special line of development may go on to a certain point and to a certain point only, when that individual form of life retrogresses, because unable to meet the changing environment. Man is no exception to this rule, and just as soon as he is prevented from exercising all of his functions, he, too undergoes retrogression. The same law applies to a community, however large or small; it applies to a state; it applies to a race, as history has shown us over and over again. Why not take a lesson from the present war? There is nothing which should impress us today as does this great world war. While it has been the greatest horror that the world has ever seen, I look upon it as the greatest benefactor that the human race has known. It is a process of evolution which was inevitable. It had to come. There was no other way of bringing about changes which were absolutely necessary. In the beginning of the war the world looked with wonder at the marvelous efficiency of the German army. And why? For generations the German has been trained for that one particular purpose. He had specialized along that line until he had reached the pinnacle of perfection. In order that he could come to that state of perfection, there was a time when the German nation had to introduce health insurance, the purpose being to relieve the individual of the obligation and the necessity of caring for himself and his family to that extent so that he could devote a greater amount of energy to building up the state machine. What has happened? The machine has crumbled to the last foundation. Nothing will be left of it, but there will arise a people who, for the first time in many generations, will taste the blessings of individual liberty.

England has introduced health insurance. Have any of you visited England, the industrial centers, and seen the poverty and the squalor of not only the men and the women working in the factories, but of the children in the streets? I have. I have seen little children raise their hands and call, "Master, Master, a penny." Is that the way to develop a race of people, men and women working in factories for 15 shillings a week? Gentlemen, I paid a bill day before yesterday for

ordinary labor, rubbing my floor—40 shillings a week? No, a day. Forty shillings a day. A man would come to my house at eight o'clock and go home to a good lunch the same day at noon, and earn more than the man working in a factory in England earned in a whole week. Do you want to compare the man here with that man? Do you think they need here what those men need? At the beginning of the war there wasn't a worse governed country on the face of the earth than England. Charity box after charity box hung in every public place; in every hotel the walls were lined with them, begging for this hospital, that dispensary, or some other charity. Even at the railroad stations there were dogs running around with charity boxes on their backs. Is that a sign of development or progress or civilization? Absolutely, no. It is a sign of decadence, just as certain as can be. Health insurance was put in force as a sop to the poor. More charity. The nation that is built on charity is doomed to destruction.

There is going on now the greatest revolution that England has ever seen; reconstruction of industrial conditions; reconstruction of everything pertaining to the social fabric, and prominent in the place of the reconstruction is the reconstruction of the health insurance act. It is not a success in its present form.

The condition of physicians from the standpoint of medical practice has already been mentioned. I have been through England, Germany, all of Europe. There is not a civilized country on the face of the world, where the intelligence of the average physician is as low as it is in Germany. In the little hamlet, in the big clinic, in the big city and among the people. Why? He makes his bread and butter at the *krankenkasse*, and no place else. He has no way of making a living except under the insurance act. A mark a visit, and less. The same way in England. What was the condition of England after it had been in the war but a few months? What department necessary to the army failed first in England? The medical department, because there were not enough physicians to properly equip the army. Few doctors in England are able to earn a decent living until they are 45 years of age. How could they, with the laboring class, the majority of them, getting ten and twelve and fifteen shillings a week, and raising a family? Talking

to the surgeon general of England, personally, I was informed that England had only one doctor to a thousand men at the front. I happen to be a member of the Surgical Society in this country to which England first appealed for help. She said: "For God's sake send us surgeons." They had one surgeon to a thousand men. We provide our army with seven to a thousand.

The state can do a great deal to help the people in health matters. It cannot do it by relieving the individual of personal obligation. I have had personal contact with the poor in Chicago for thirty years, in dispensary management and taking care of the poor. A city should never look with pride on its charitable organizations. The more charitable organizations that a city or community has, the bigger the disgrace. People do not want to live by charity. Charity is not a sign of enlightenment. It is a sign of something rotten in the community, and when our communities are properly run there will be few charitable institutions. Every charitable institution we have is just one more blot on our civilization. Every one that we wipe out is an evidence of evolutionary development.

Now, there is a difference between doing something by the state for the benefit of the health of the community, and creating charitable institutions, or charitable methods. It is the state's duty to provide the opportunity for the individual to care for himself, and when the state does that properly, there will be no demand for charity. The state can do a great deal in public health matters. It can do a great deal in building up so-called social service centers, but these centers should not be purely charitable. Hospitals should not be entirely charitable. Every patient that goes to a dispensary or to a hospital should pay something, and when the community is on the right basis every patient will be able and glad to pay. We have had a dispensary here for thirty years, and the patients that go there are proud of it. They go there with some feeling of manhood. Every patient pays something, it may be only five cents, or ten cents, or a quarter. Where dispensaries are run on a charitable basis pure and simple, patients may be seen going from one to the other. If they do not get the medicine they like at one place they throw it in the alley, and go to the next one, but the man who goes to the dispensary and pays something for his medi-

cine, takes it home and uses it. We want every man to be able to find the medical service that he requires, but we want every man to pay for such service what he is able. It is up to the state to make the conditions such that he is able to provide the necessary means for paying for that service. That is proper evolution and proper development and proper progress. Everything that creates a need for charity is an indication of something wrong in the community.

DISCUSSION.

MR. WEBSTER: As a society, Doctor, are you people doing anything in the way of formulating plans on recommendations, either in contemplation or actually performed, toward having the scope of our State Board of Health enlarged and increased, and to make it more efficient so that they can better develop or be able to develop work along these lines of prevention?

DR. HARRIS: I cannot speak for the society, because I have not been intimately connected with the doings of the state society along that line.

MR. WEBSTER: I was wondering if any of the medical societies that you know of have been taking it up in that way; that is, have they been co-operating, for instance, with Dr. Drake and his people and trying to assist them in the development of their work in a broader way or in a more efficient manner?

DR. HARRIS: Yes, the American Medical Association, for which I can speak, has been doing that for years.

MR. WEBSTER: It occurred to me that possibly they might be able to render a great deal of valuable service in cooperating.

DR. HARRIS: They are always only too glad to do it.

COMPULSORY INSURANCE*

JOSEPH FAIRHALL, M. D.

DANVILLE, ILL.

Mr. Chairman and Members of the Commission:

Having been appointed by the President of the Vermilion County Medical Society a member of a committee selected to investigate the matter of Compulsory Health Insurance, I have given considerable thought and attention to the matter, and have procured as much data as I could upon the subject, and with your permission will proceed to lay before you the result of my investigations, as it appeals to me.

When I first sought information upon the subject I was led to believe that it was a matter

*Paper read before the Illinois Health Insurance Commissioners, as representing the Vermilion County Medical Society, Nov. 16, 1918.

calculated to materially benefit the laboring man, and I therefore turned to the vast field of labor for information, presuming that it emanated from the labor organizations.

This I found was not the case, but that it originated with the "American Association for Labor Legislation," having its offices in New York, and I supposed forming part of the Labor Organizations of the country.

I find, however, that in its personnel and officers, no claim is made as having any official connection with the labor organizations whatever.

I further find that the idea is not original with this Association for Labor Legislation, but is a replica of a system adopted and used in Germany and Austria for some years, and later introduced into Great Britain.

Upon investigation as to the working of the system in the countries named, I find it has by no means proved the Utopia that it was hoped for.

In Germany under the system sickness has increased, the loss to the world of industry has been greater, while the cost of handling the insurance itself has been much higher than it was originally expected to be.

Statistics show that the average number of days lost to labor by sickness annually is nine, and yet it is asserted that the German insured annually draw benefits for an average of twenty days each; therefore if nine is the average number of days lost by sickness, the loss of the other eleven must be attributed to some other cause.

Having been born and educated in England, and therefore more conversant with its peoples, its manners, and its customs, I have given more attention in the course of my research to that country, and the methods employed in the matter of compulsory insurance by the British Government.

For this purpose I placed myself in correspondence with men upon whose statements I knew reliance could be placed, and through whom I have received much literature, in the shape of Parliamentary Reports, etc., upon the subject, which have been very helpful.

In the course of my inquiry I have not confined my reading to the British "*Lancet*," the "*Journal of the British Medical Association*," or other special medical literature, but have rather

gotten my information from the reports of the Commission on Health Insurance, as laid before the English Parliament.

I find that the Act as passed by the British Government, which practically went into working order in 1912, embraces a system of insurance for men and women in accordance with certain provisions, too numerous and cumbersome to be introduced at this time.

Briefly:

The insurance as applied to men, covers all over the age of sixteen and under seventy, whose maximum earnings are not beyond £160. (\$800.) per annum.

A card is issued to each person at the time of insurance and thence after is renewed quarterly, which card must be produced by the employee when required by the employer for stamping.

The cost of the insurance for men is 14c per week, eight cents of which is paid by the insured and six cents by the employer, the State also paying the fractional amount, which is supposed to provide for the working expense of the insurance.

Payments are shown by stamps affixed to the cards spoken of, the stamps being known as "Health Insurance Stamps" which may be purchased at any Post Office in the United Kingdom, the employer being responsible for affixing them at proper intervals, and the right amount.

This 14c provides for the insured, *his family or dependents*, treatment by a qualified medical practitioner, together with necessary drugs and medicines; it also pays a weekly benefit to the insured of ten shillings (\$2.50) per week for twenty-six weeks of sickness, and five shillings (\$1.25) per week if disabled after that period.

Doctors are asked to render professional services, in which case their names are placed upon what is known as a panel; the insured selects from this panel the Doctor whom he wishes to attend him, and a contract is entered into between Doctor and patient for one year, the doctor receiving for his services (which he must give whenever called upon) the sum of \$1.75 per year.

The maximum number of insured allowed to any one Doctor is five hundred, therefore supposing a Doctor able to secure the maximum number, he derives an income of \$875 per year, and considering that not only the insured but the *whole*

family or dependents, are included in the contract, we know from practical experience the calls that would be made upon the Doctor, when his services may be obtained at any time free of cost, and I have no hesitation in saying that the Doctor would have to work very hard for the small amount that he would receive.

The Commission having this insurance in charge have the right to remove any Doctor's name from the panel, at any time, "for cause," or assess a fine. During the year of 1916, I find that twenty-two inquiries were held by the Commission, resulting in the removal of fifteen Doctors from the panel, two of the remainder being assessed fines of one and two hundred dollars respectively.

It must not be supposed that this Act went into force, or became law, without meeting with strong opposition, and we find from the Parliamentary reports that the medical profession bitterly opposed it.

The British Medical Association informed the Government, "that it would call upon the whole of its members to decline to form panels, or undertake any other medical duties assigned to them under the Act," and the following pledge, signed by twenty-six thousand (26,000) medical practitioners was presented; the pledge reads as follows (Book 1, p 125):

I, the undersigned, hereby undertake that, in the event of the National Insurance Bill becoming law, I will not enter into any agreement for giving medical attendance and treatment to persons insured under the Bill, excepting such as shall be satisfactory to the medical profession and in accordance with the declared policy of the British Medical Association; and that I will enter into such agreement, only through a local medical committee, representative of the medical profession in the district in which I practice, and will not enter into any individual or separate agreement with any approved society or other body for the treatment of such persons.

The doctors further claimed that the minimum fee per capita should be \$2.12 (8/6) per annum, not including extras and medicines, and that the earnings of the insured should not exceed \$10.00 (£2.) per week or \$520 per year, and several other stipulations, the whole of which were negatived by the Commission, but an allowance of six pence, or 12c per capita was added to the doctors' fee for domiciliary attendance upon tuberculosis patients.

The negotiations between the Government and

the British Medical Association extended for over a year without anything definite being arrived at, and on January 17, 1913, owing to the exigencies of the war the British Medical Association notified its members, "that under the circumstances they were released from their pledge and free to use their own judgment" this was done in order that no embarrassment might be placed upon the Government; after which we find the insurance system in force with about fifteen out of the twenty-six thousand physicians on the "panel." This number was increased by April, 1913, to eighteen thousand five hundred eighty-four (18,584), while the number of insured at that date is given as three hundred twenty thousand, five hundred thirty-seven (320,537), thus forming an average of seventeen patients (or insured, with their families) to each doctor, the annual income from which would total \$27.15.

Of course these figures are arrived at only by striking an average, in many cases no doubt the number of insured on the doctor's panel would be largely increased, especially in the thickly populated districts and industrial areas. But even at the best, and supposing that a doctor has the maximum of five hundred insured on his panel, at the rate of a dollar and seventy-five cents (\$1.75) per head per annum, would we reasonably expect the best men in the profession to accept these conditions and give their best service for such a pittance?

Such a law applied to this great, free country, would in a few years cut down the numbers of doctors in each State, and at the same time stop all research, and medical progress.

If we were asked, where have many of the most important factors in the practice of medicine, and the prevention of disease originated, we should answer truthfully, and with pride, that most of them are due to the research of the doctors of the United States of America.

On the other hand, Marion Sims, Nicholas Senn, the Mayo Brothers, J. B. Murphy and a long list of others who have contributed to the making of the name of America famous in the world of Medicine and Surgery, would never have been able to give us the benefit of their splendid experience had they been hampered by a Cheap John system of medicine, on a par with a ten cent store business, frittering away their

time and talent upon a pauper practice in order to eke out an existence. These men performed their quota of charity work, they gave of their best means and their ability freely, and they earned what they gave, nobly and consistently, in keeping with the ethics of their high profession.

Another factor which would largely militate in cutting down the ranks of the medical profession, is that parents would refrain from educating their sons to be physicians. They would feel that the large investment necessary to qualify a young man to practice medicine could be better employed as an investment, giving a much larger return, if used in the mercantile world.

A boy today to be educated for the medical profession must pass through the common grades and enter a High School, which he would as a rule do at the age of fifteen; he graduates from the High School at nineteen and enters a University, where he spends another four years after which he is eligible to enter a Medical College, where after five years of hard study he may graduate with the degree of Doctor of Medicine. His education however is not yet completed; he has to take the State Board examination, and serve as an interne for at least a year in some hospital before he can obtain a license to practice, so that by the time the boy is turned out as a full fledged doctor he has arrived at the age of twenty-nine years. Figure the expense incurred during these years for food, clothing and education, and the sum total is a very large one running into several thousands of dollars, and he then is to suffer the humiliation of being requested to give these costly services, according to the price paid in England, for the paltry sum of a dollar and seventy-five cents per head for patients, and if successful in procuring a maximum panel he can count upon the magnificent sum total of eight hundred and seventy-five dollars for a years' work.

Compare this with labor; a boy at the age of 16 may enter a coal mine, and commence to learn the method of mining coal, at once he earns from a dollar and a half to two dollars per day; in a year or two he is qualified to "dig coal" and his earnings from now on rapidly increase, so much so that by the time he is twenty years of age he can earn from seventy-five to one hundred and

fifty dollars a month, depending entirely upon his own capacity.

It is possible therefore for the coal miner to average at least twelve hundred dollars per year, as an income, *without a preparatory outlay of one cent*, while the expensively prepared physician is asked to accept a maximum wage of eight hundred and seventy-five dollars.

It may possibly be said in extenuation of the proposed panel practice that it will not prevent a doctor from private practice, which no doubt would be true, but we may ask in reply how much time is a doctor having five hundred families to attend to, likely to have, in which to attend to private practice, unless he be guilty of neglect, which he would have to be one way or the other; it would be either panel or private practice, which must be patent to all.

For a moment let us consider this phase of the question. Suppose a doctor called to visit Mr. Smith, residing a mile or two away, who is a panel patient, and before the doctor starts, Mr. Jones, a private patient living a few blocks away requests the doctor to make him a visit. In the first case the doctor is receiving a yearly pitance, and in the other he is paid two dollars and a half for each visit; is it necessary to ask ourselves the question, which will be attended first?

The medical profession of Great Britain has loyally laid aside its grievances in order that during these troublous time, the Government should not be embarrassed, but that does not follow that the profession is satisfied with the conditions as they exist, and we find that the number of doctors applying for panel practice does not increase, but on the contrary according to the Parliamentary reports for the little country of Wales submitted for the year 1917 we find that whereas on January 1, 1915, there were one thousand, two hundred, twenty-two doctors on the panels, on the 1st of January, 1917, there were only one thousand and ninety-nine, showing a decrease of one hundred and twenty-three.

A recent article appearing in the *British Medical Journal* depicting the difficulties of the medical profession says: "There is undeniably throughout the country a feeling of unrest and dissatisfaction on the part of the Panel Practitioners with the condition of their work under the Insurance Act."

Dr. Brackett of Rayleigh in the county of

Essex (England) speaking on the subject says: "In taking over our incomes and distributing them at its will, Parliament has been guilty of a monstrous invasion of civil rights,— it is the wickedest thing that has been done in Parliament since the days of Charles the Second." Dr. Donington, in a letter published in the *British Medical Journal* under date of June 3, 1916, among other things has this to say, speaking on the insurance system, "The effect is not good! The moral effect has been bad;—It makes the not very scrupulous man a lazy, deceitful malingerer."

This latter clause of Dr. Donington's letter is one of the greatest rocks which will lie in the channel in this country, and the doctor that can steer always clear, will prove himself more than an ordinary pilot.

It is a fact that in America most of the industrial and artisan classes are already insured against sickness, being members of one, two, or three, sometimes more, Benefit Societies, and to use Dr. Donington's classification, "a not very scrupulous man" would find it greatly to his financial benefit to be sick often, and for as long as the limit will allow.

Supposing a man (and I am personally acquainted with several) who belongs to the Society of Odd Fellows, the Knights of Pythias, and the Modern Woodmen, is taken sick, he is paid by the Odd Fellows seven dollars per week, with the addition of an allowance of ten dollars and a half for hospital expenses, if this is necessary. These amounts are allowed for twenty-six consecutive weeks; he will also draw from the Knights of Pythias, five dollars per week, and from the Modern Woodmen, three, thus giving a total income of fifteen dollars weekly, not counting the hospital allowance, and if under a compulsory insurance he should be allowed another five dollars weekly, I can readily see that the doctor in attendance would have a hard time in declaring him off the sick list. It very clearly offers a premium for malingering, and in order to more fully show this I will state, that records show that Germany in 1890 without compulsory insurance listed thirty-six per cent of its population as sick at one time or another during the year, while in 1913 under compulsory insurance the average proportion showed that the percentage had risen to forty-five.

Austria for the same period gives about the same proportions under like conditions, therefore we are justified in saying that compulsory insurance does not tend to lessen the number of sick.

Of course, Members of this Commission, in making up your report, all the points which I have endeavored to set before you will be carefully considered, and when all are calmly reviewed, I feel sure that you will not recommend any system of insurance based upon the vassal system of Germany, or the pauper system of England. You will not favor any system, I am sure, that will tend to foster a class by itself, in the citizenship of this great Democracy, or suggest that the American Citizen, be he laborer or Banker, Store-Clerk or Congressman, is incapable of looking after his own interests to the extent that a conservator should be appointed for him, owing to his incapacity to take care of his own affairs.

QUACKERY REPORT OF THE COMMITTEE APPOINTED BY THE DOUGLAS PARK BRANCH OF THE CHICAGO MEDICAL SOCIETY.*

HENRY R. KRASNOW, M. D.,
CHICAGO

Ladies and Gentlemen: About a year ago it was my pleasure to read a paper before this society on the subject, "The Foreigner a Prey of Medical Quacks." In that paper I endeavored to present to you the fraudulent and dishonest practices of the medical charlatans, who are robbing us of our legitimate income, and also pauperizing the poor and ignorant foreigners in this country. I had stated in my conclusion then that the reasons underlying this condition are: 1. Ignorance of the foreigners; 2. Distortion of the idea of personal liberty by clever lawyers, giving the quacks a standing in court; 3. The quacks are organized, and 4. The apathy of the medical profession.

A committee was appointed to study the question and report a detailed plan of action to combat the quack. The committee reports that although much can not be accomplished in so short

*Read before the Chicago Medical Society, Douglas Park Branch, May 15, 1918.

a time and under the circumstances, yet we are on the right trail to success.

The committee is in possession of numerous copies of so-called "literature" which is being distributed by the medical quacks among the foreigners in various languages. We have also considered the many foreign language newspapers, most of which are carrying quack advertising; it seems that the latter are a very significant factor, which helps the quack far more than the various pamphlets and booklets distributed by the quacks among the foreigners. We are also in possession of a number of individual cases of mistreatment by the quacks.

While the question of propaganda by the American Medical Association was considered to be of great benefit to both the medical profession and the public, as well as the recent appointment by the Chicago Medical Society of a grievance committee for the purpose of dealing with the question of medical quackery, and the recently announced exposures by the *Chicago Tribune*, the committee appreciates the necessity of broader and more detailed enlightenment of the masses, by way of organizing popular health clubs or societies; distributing popular hygiene pamphlets and other literature pertaining to health and proper living, in various foreign languages. It was also pointed out that the question of fighting the quack is never or very seldom the subject of discussion at the various federal or state medical societies, this subject, though, being of great importance to the medical profession and to the entire community, from the standpoint of popular health.

While the councils of these various federal and state medical societies have several important committees branched out, such as ethical, educational, etc., there lacks a similarly important branch, that of studying and solving the question of medical quackery.

The ethical physician in his private practice, although anxious to educate his patients to the real issues of quackery, is technically unable to work in this direction, for the reason that oftentimes he does not possess the desirable information needed to prove to his patients certain items of importance.

Your committee thought it advisable to consult the medical profession at large in regard to the question of quackery, and a number of copies of the paper, "The Foreigner a Prey to Medical

Quacks," was sent to various prominent and distinguished members of the medical profession, with requests to express their views on the question. Some were interviewed personally.

While the majority of the medical profession consider the question of quackery one of foremost importance, which should be followed up with utmost care and concern, others, although agreeing this question to be important, think that there can hardly be much attained towards eradicating this evil, because considerable work was done in this direction without favorable results.

Below we are stating some of the most interesting extracts from the replies by leaders of our profession, to whom paper was sent.

The committee's suggestions are as follows:

1. The laws governing prosecutions of the quacks are very lax; usually a fine of a few dollars, which, by the way, the quacks manage seldom to pay. Strict and rigid legislation has to be instituted classing medical quackery equal to any criminal offense.

2. The American Association of Foreign Language Newspapers, which supposedly has for its aims the welfare of the immigrants of this country, should institute a censorship over all the medical advertising in every newspaper issued in this country in the foreign languages.

3. The American Medical Association should include in its program a wide propaganda pertaining to the question of enlightening the laity as to the activities of the medical quackery and its evil doings; this propaganda to be carried out by means of popular literature printed in several foreign languages, and distributed broadcast.

4. The general practitioner must consider it his duty to get information on every possible case of medical quackery. He should at any time possess some ready and rapid-fire means to participate in the work of fighting the quack, or at least, to communicate his findings to the proper channels.

5. A special committee should be appointed with the primary aim in view to further the study of the question of medical quackery; this committee to work in conjunction with the Grievance Committee established by the Chicago Medical Society. The Committee to be provided with an adequate appropriation for literature,

postage and other expenses attached to the work.

Each one of the above enumerated suggestions requires special study and it is the intention of your committee to prepare a series of reports on those items.

For the present, the committee appreciates this the proper time to suggest that The Douglas Park Branch of The Chicago Medical Society through its councillor asks for a resolution to be passed which will create a special Committee on Quacks to work in conjunction with The Grievance Committee of the Chicago Medical Society.

DISCUSSION

DR. F. GLENN reported the splendid work achieved by the Grievance Committee of the Chicago Medical Society, of which he is chairman. Since the time of establishing of this committee, much was accomplished toward learning the conditions about medical quackery, due mainly to the new state laws created by the Board of Registration. According to the laws of the Board of Registration, "persons practicing medicine on false or fraudulent representation," "persons practicing medicine and accepting money on false or fraudulent representation of his profession," or "persons who are advertised under else than their own names," are subject to strict punishment by the state. It is by the assistance of these laws that such notorious quacks as Drs. Blunt and Hodgens were prosecuted and their licenses were taken away. The speaker invites the medical profession at large to assist the Grievance Committee in its work, promising that every information will receive immediate attention of the Board of Registration, which is greatly interested in the welfare of the medical profession.

DR. G. APFELBACH also cited some experiences of the Grievance Committee of which he is a member. In his opinion, the work of eradicating the evil of medical quackery cannot be accomplished in a very short time; it will take at least five years to bring about desired results. Proposes that every branch of the Chicago Medical Society elects a special committee for the special purpose of informing the Grievance Committee about the work on the subject of the medical quackery. Also suggests that the Board of Registration be provided with funds for the purpose of successfully handling this particular work; it would be quite proper to establish a registration fee as proposed by Dr. Shepardson, in charge of the Board of Registration; registration fee is to be One Dollar per year, to be paid by every licensed and practicing physician in the State. This process will also enable the State to stamp out the evil of fraudulent medical diplomas.

DR. SOKOL cited some very unpleasant experiences, following his attempt to prosecute a case of medical quackery in the courts. More than two weeks were unnecessarily spent on account of "red tape." Every

time he would be told that either the case was not ready for trial, or some witness did not appear; consequently, the case was tried without him. Such state of affairs, naturally, prevents the physician from following up the work of prosecuting the quacks.

To this, Dr. Glenn explained that hereafter such procedure is uncalled for; all that is necessary is to notify Dr. Shepardson about any case of quackery and the Board of Registration will do the rest.

Following the discussion, a permanent committee for the purpose of dealing with the question of quackery was elected by the Douglas Park Branch.

COMMENTS

DR. WILLARD J. DENNO (Secretary New York State Board of Medical Examiners): I have read your article with considerable interest, touching as it does upon a subject that is very vital to the welfare of both the medical profession and the laity. This problem is under consideration in many, if not all the states of the Union, and will unquestionably be solved, together with other social and economic problems, as our nation in the course of its evolution finally finds itself. It seems to me that there are two points of attack in attempting to solve this question: 1, the education of the laity; 2, adequate legislative control of all who practice medicine. You will appreciate, as we all do, that the education of the laity to a sufficiently high degree to insure avoidance of quacks and charlatans is a very slow process. It is a matter not of years, but of generations. In the meantime, the regulative control by statute of all who hold themselves out as being able to practice the healing art should be made more stringent. The medical practice act of each state should contain a clause providing for the revocation of the license of any physician who allies himself with and serves as a cover for the practice of quacks. This clause should be a broad one, covering all branches of medical ethics, and would, in my opinion, materially assist in cleaning up the profession. Then it will be necessary for the legislature to appropriate an adequate sum to provide for inspectors to obtain evidence against unlicensed practitioners, and prosecution of these offenders should be in the hands of the attorney general of each state. With such legislation to control matters until the education of the masses is completed, a material gain over present conditions will be reached.

DR. CHARLES J. WHALEN (ex-President, Chicago Medical Society): I believe we are dealing with a very difficult problem and that in which very little can be brought about in the way of reform by any individual efforts. By united effort we can ultimately clear up the quack situation.

DR. SAMUEL G. DIXON (Pennsylvania Health Commissioner): I have frequently had occasion in official newspaper interviews to point out the danger of the miscellaneous use of drugs. Unfortunately, we have no set laws in this country for the control of such impostors, and now that they are driven out of the English language newspapers, where such inspectors are trying to protect the public, these advertisers have found the foreign trade worth catering to.

DR. WILLIAM C. WOODWARD (now Health Commissioner of Boston, Mass): The work you have undertaken is worthy of support and should be pushed with the greatest possible vigor. The exploitation in this country of ignorant foreigners by shrewd and unscrupulous persons of all races is one of the factors tending to prevent the thorough Americanization of such immigrants.

DR. WILLIAM BRADY: It is a subject which ought to be constantly kept before medical organizations everywhere. The giant frauds of quackery and the nostrum evil are ten times worse than a doctor likes to confess. They are taking up millions of dollars which ought to go into the pockets of the most unappreciated and unfairly treated laborer in the world, the family doctor.

In my newspaper work (my articles are syndicated to a large number of daily papers in the United States and Canada), I do all in my power to oppose the damnable trickery and deception practiced by these vultures. In nearly every article I write I endeavor to insert something which will create doubt in the mind of the credulous reader who is interested in some aspect of nostrum or quackery. This kills me with many newspapers. In the South, especially, they are very likely to object to my "style." One Southern editor recently threw me out of the paper because my "style" tended to shake the faith of the readers in patent medicines, and "patent medicines were a godsend to the people," in his opinion. I prize his letter as a pretty fine testimonial.

A doctor in Reading, Pa., recently wrote me that he was sorry to see me in such bad company, and he enclosed clippings of some pretty rotten nostrum lined up alongside my health talk in Reading paper. Well, I couldn't blame the doctor; in fact, I urged him to bring about an organized protest from the medical profession and self-respecting citizens of the place. But I am a mere contributor, and usually editors and publishers do not consult me about advertising.

But, privately, I do a whole lot to hurt the crooks. I never let slip an opportunity to show up a crooked man in my large correspondence with readers. Never a day but that I have the chance to steer contemplative patients away from such fakers. In this I find the A. M. A. Directory invaluable, and the many reprints of A. M. A. exposures come in nicely in acquainting readers with the fakes.

I now earn my living writing, and my practice is secondary. The first medical article I ever wrote was about the proprietary evil in practice. I read it before the local Chemung County Medical Society and published it later in the *New York State Journal of Medicine* (official organ of State Medical Society).

I believe that if the general profession could clean house first—cease biting on the bait trailed before it by the drug agent, the detail man, the medical journal without advertising conscience—it would be entirely possible, by public education, to eliminate both the quackery and the nostrum evils from modern life. These evils are already on the decline, but too slowly, because we think silence is dignified.

From my acquaintance with newspaper publishers, I find them different people than I used to imagine they were. I find the majority of them, the better class of publishers, really want to run fairly clean papers, and do not want to publish deliberately crooked advertising. For instance, when I was fighting out the Chester pill matter with the staff of the *Eagle* (I attended an editorial conference), the advertising manager stated that the ad had been running for something like thirty years, and in all that time no Brooklyn doctor ever made any protest about it. I had to find an excuse, and I suggested that no doubt the doctors assumed that a paper which would publish such a rotten advertisement would only resent any objections from decent physicians or other respectable citizens. But why in hell didn't a Brooklyn doctor, or the Brooklyn organized profession, file repeated complaints and protests? Why don't doctors everywhere adopt such a policy? There is only one reason that I can see. They lack the nerve. They are moral cowards. They are too much tangled up in proprietary medicine themselves.

Keep at it, Dr. Krasnow. It is work which is sorely needed, and you are helping your profession every time you read or publish such papers.

DR. HARVEY W. WILEY (New York): If foreigners are any more susceptible than native Americans to the propaganda of quackery, I feel sorry for them. I am sorry to say that many so-called physicians are also dispensers of so-called patent nostrums.

I hope your paper will be translated into the various languages spoken by the many different races in Chicago and widely distributed. I am doing what little I can to enlighten people to the evils of the nostrum.

DR. GEORGE B. HASSIN (Chicago): The facts brought out by you are unfortunately too true and I hope your endeavors will stimulate the medical profession to take some active and decisive steps towards complete eradication of this terrible evil, through which crimes are committed by various charlatans and thieves upon helpless and unfortunate foreigners.

DR. JOHN DILL ROBERTSON (Health Commissioner of Chicago): The suggestion as to the proper procedure to curb the evils referred to is especially timely in view of the campaign recently undertaken by the State Board of Registration and the *Chicago Tribune*. There is a reasonable prospect that the present campaign, owing to the new powers of the Board of Registration, will put medical practice on a higher plane.

DR. GEO. F. BUTLER (Winnetka, Illinois): It should be translated into various languages and given free circulation, for many foreigners in Chicago and elsewhere are unfamiliar with medical ethics and do not know when a doctor advertises either himself or a patent remedy said to cure all manner of diseases that nine times out of ten the man is incompetent and the remedy of no value. They should be educated and made to understand that the way to do is to patronize a reputable physician. The state and national medical societies should bring out literature in all languages explaining this matter and successfully fight the organized quack. It is purely a matter of education.

DR. FRANCIS E. FRONCZAK (Health Commissioner of Buffalo): This brings realization that something is radically wrong and that something radical should be done, and further excites indignation that such a condition should be tolerated, and such professional apathy should exist. Your presentation of the facts are as interesting as they are formidable. I question if so much information on the subject has been given before in so few words and it ought to be read by every medical man in Illinois.

DR. HERBERT S. NICHOLS (Secretary Oregon State Board of Medical Examiners): The facts as you have stated them are absolutely true. The foreigner looks upon an advertisement as gospel truth and accepts treatment from an advertisement in preference to honest treatment by a reputable man. There has been an effort from the Health Board of this city to eliminate quack advertisements from the newspapers, with only the success of eliminating diseases of men and other advertisements which claim to be able to heal incurable diseases. This is a step in the right direction, but is not all we could wish by any means. It is difficult to persuade newspapers to give up remunerative advertisements regardless of whether it is honest or not.

DR. B. B. GRIFFITH (Health Commissioner of Springfield, Illinois): The eradication of these pests should be done by state authorities, aided and assisted by local medical societies or individuals acting under medical society authority.

DR. HUGH T. PATRICK (Chicago): It seems quite needless to say that any propaganda of this sort is exceedingly useful and my only regret is that more is not written on the subject. I presume that the unsophisticated immigrants suffer more from this quack work than do others, but no class of people is exempt. And sometimes the millionaires on boulevards fall for the thing as easily as those who have less opportunity to inform themselves.

DR. THOMAS McDAVITT (Chairman Board of Trustees, American Medical Association): The quack question is a very important one, not only to the foreigner, but to the citizen generally. The misfortune of the whole matter depends upon the point of view of the public and the commercialism of the newspapers.

It makes no difference how vicious the claims of a quack or how self-evidently untruthful the statement in reference to medicine, the average newspaper will print the matter without asking any questions. They do not seem to be any more conscientious than the average citizen, as is evidenced by the almost constant decision of juries in favor of the quack and his methods if brought before the courts.

The position the legislators of the different states often assume in reference to bills brought forward to prevent these creatures from gulling the public is a matter of regret. The inability of the medical profession, except after much labor, to increase the standards of medical education has long been evident, as you know it was only after many years they were able to get any sort of a law in Wisconsin simply because

the matter was fought by one of the principal newspapers of the state, undoubtedly from commercial reasons.

It would be a matter of great importance if you could be successful in your fight, and you certainly will have all of the co-operation I can furnish.

DR. B. COURSHON (Health Commissioner, Sioux City, Iowa): I presume the foreigner in your city is the chief prey. Here, however, it is the farmer, and for the same reason: he sees the big ads in the papers, and he believes them implicitly. The same holds true in regard to patent medicines, especially when such men as U. S. Senators give their endorsement (your former Senator Mason is one of them). The remedy? Prohibition of the ads which cannot be substantiated and their exclusion from the mails.

DR. BERNARD FANTUS (Chicago): While agreeing with you heartily in the stand taken by you in this article, and hoping that your committee will help in solving this sore problem, I would suggest that you had better not dwell much on the financial harm done to the medical profession by quackery. As a matter of fact, I would not be surprised if it were found that this financial loss is more than made good by the income derived by the medical profession from cases rendered chronic or incurable by the ministrations of the quacks. It is, on the other hand, bad policy to admit that it is our financial interest that prompted us to make war against the quacks.

MR. L. HAMMERLING (President American Association of Foreign Language Newspapers): When the *Chicago Tribune* had gotten the quack doctors, I came to Chicago and we inaugurated a campaign in the American Foreign Language Newspapers and we believe we have succeeded for the time, for the best of our papers refuse such advertisements and have run quite an industrious campaign on it.

We have done likewise for others in practically every large city in the United States, but the trouble is that your organization, as well as other medical organizations, do not have an organized method of handling this proposition. What I mean by this is, if you had an organized force of national, or even local young men, and have a writer of standing to contribute articles to the different papers warning the readers, not only as to their health, but as to their citizenship, you would succeed.

This association does not take any such business, but naturally we have no hold on the papers or have any right to dictate to them not to take it. We use our influence wherever we can.

DR. WILLIAM ALLEN PUSEY (now President Chicago Medical Society): I should think that foreign language newspapers afford the biggest avenue for quacks to reach the foreigners. I presume that source of income is so large to the foreign newspapers that it would be very difficult in influence them to cut out these advertisements. But I happen to know something about the Foreign Language Newspaper Association myself and it seems to me it might be worth while to try to get at that aspect of the situation.

THE SO-CALLED INFLUENZA EPIDEMIC
A PLAUSIBLE THEORY AS TO THE ETIOLOGIC
FACTOR WITH A PRESENTATION OF THE THERA-
PEUTIC MEASURES EMPLOYED IN THE SUCCESS-
FUL TREATMENT OF OVER FIVE HUNDRED
CASES WITHOUT MORTALITY.*

ALBERT J. CROFT, M. D.
CHICAGO.

In the preparation of this paper I have had but one thought in mind, to present in plain terms my observations on the so-called influenza epidemic.

When everybody, from a baby to an adult, greets you with "Doctor, I've got the flu," it is reasonable to assume that some widespread etiologic condition exists. The rapidity of extension of the pandemic throughout the world certainly has demanded of the practitioner quick thinking and decisive action, no matter whether the cause is psychic or material, in order to obtain satisfactory results. To assume a "watchful waiting" pose, pray the rain to lay the dust, try out a new vaccine, or wait for science to wrangle about the cause, is to increase the mortality list.

It has been proven that laying the dust does not reduce mortality, that vaccines have given little aid and that science is still hopefully working in the laboratories.

When scientific abstractions have failed us at critical moments, we of necessity must come back to earth, shoulder the burden and in our own practical way treat each case as intelligently as we may, and, so far as possible, give immediate relief and comfort to the patient.

We are told that the present epidemic is influenza, a virulent type of the old-fashioned grippe, imported to our shores from the battlefields of Europe, the quiet cities of neutral countries and agitated centers in Germany. Even if this theory is correct, still I plead for decisive action in treatment of all cases in order to prevent the endemic and sporadic outbreaks which are sure to occur for several years to come.

Now that I have impressed upon your minds the necessity for immediate, practical treatment of all cases as you understand them, regardless of the scientific theories which are now in vogue, I wish to present to you my observations of over

five hundred cases of the so-called "Flu Epidemic" and also to submit to you a theory as to the cause of the disease.

I am convinced that the epidemic now visiting our country and other parts of the world is not true influenza. This may seem rather a bold assertion for a general practitioner since our scientific brethren already have christened it, but where are the facts upon which they have based their conclusion, that this is an influenza epidemic? Up to the present time they have given us no tangible evidence. I will go still further in saying this pandemic ailment has really never been positively identified. In the absence of proofs, should we accept their dictum in regard to their biological treatment and discard the knowledge gained in therapy during a lifetime of practice?

The cause of the phenomena, whether biologic or chemic, originated in the camps and trenches of Europe. There the convenient term of "influenza" was first adopted for reasons still obscure to us. As it spread we see creeping into the literature the terms "Spanish Influenza" and "German Influenza," because of its prevalence among Germans and Spaniards and not because of any type differentiation, etiologic factor, specific symptomatology, etc. As it affected a few other nationalities, we have had since then the "Portuguese Influenza" and the "South African Influenza," and mixed in here and there a few cases of "Irish Influenza."

In its spread to the new world, we at first nursed the most original type, the "Spanish Influenza," but being Americans, we had to drop the word "Spanish" and simply called it the "Flu," an American Flu. Our southern neighbors, the Brazilians, refused to accept it as an influenza epidemic, so different had the medical profession of that country considered the phenomena from the well-known Leichtensternian types.

It is regrettable that the notoriety given these phenomena under the guise of a serious influenza epidemic has caused a great deal of unwarranted fear in the minds of the people, which has considerably weakened their already depressed wartime nerves to such an extent that they have become easy victims to pneumonia and other diseases. Indeed, when we are called to see a patient, we in-

*Paper read before the Douglas Branch of the Chicago Medical Society, November 13, 1918.

variably find an excited household, and the first important obstacle to overcome in the patient is a general nervous breakdown from fear, due to the belief that he is an influenza victim and therefore a sure candidate for the graveyard.

Relieve his mind from the "influenza panic" by diverting his thoughts into more pleasant channels and refusing to accept offhand the family diagnosis of "influenza" and you will have defeated the greatest menace of this malady.

In regard to the etiologic factor, we are informed that some investigations hold a micrococcus responsible for the assault, while others attach the guilt to members of the bacillus group. It is a proven fact that all previous epidemics of influenza vera were attributed to the very minute bacillus of Pfeiffer. This organism, however, so difficult to seed on the usual microbial foods, presented difficulty in isolation. Nevertheless, it was found to be constant in 20 to 50 per cent of all cases, according to Rosenau of Harvard. Have our scientists been able to isolate the Pfeiffer's bacillus in the majority of cases of this epidemic? If they have failed to uniformly associate this organism with the condition, why call it influenza? So far as a specific bacterial theory is concerned in this epidemic, I so far have been unable to credit it. Is it not possible that the normal bacterial flora of the nose and throat have gained ascendance in this epidemic? It is natural to assume that they find good soil for growth and transformation into pathogenic types in a frightened, physically exhausted, nervous individual. I believe they are very important as a secondary factor and the increase in deaths from pneumonia may be attributed to this cause.

In the absence of positive proof of a specific bacterial cause, and after due and careful consideration of the course and symptomatology, of the many cases under my observation, I have arrived at the conclusion that if our scientists were to make a careful chemical, geological and meteorological survey of the countries now affected by the so-called influenza, some irritated condition of the atmosphere would be found which would account for the cause and rapid extension of this ailment.

The numerous gases used on the battle fields of Europe, with their highly poisonous properties, the liberation of a large quantity of ground air

high in carbon dioxide content due to trench systems, the gases from decomposing bodies of men and lower animals; and those set free by the destruction of cities and ammunition dumps during the last few years, may have combined to form a gaseous compound with highly toxic properties probably due to the rearrangement of molecules by the tremendous concussion produced by high explosives. With this idea in mind I am going to advance the theory that the condition termed influenza is in reality a non-bacterial, non-contagious disease caused by the inhalation of small amounts of a depressing, highly irritating, high density gas, present in the atmosphere, especially at night and when the air is surcharged with moisture, more particularly near the surface of the earth.

That vegetation has suffered likewise from this "gas poisoning" which has impregnated the atmosphere of our cities may be recognized by the significant statement of an old farmer, residing in Marinette county, Wisconsin, who, on noting last August the feeble and withering condition of his crops without any apparent cause, made the following unusual remark: "When vegetation perishes under favorable conditions for growth, it may be taken as a sign of trouble for the people." This farmer, accustomed to recognize the relations between nature and its creatures, saw in the withering vegetation, occurring under favorable conditions, a premonition of pending disaster. He felt that if no usual causes could be found which would explain the perishing of his crops, there must be something lying low in the atmosphere which surrounded his plants and therefore encompassed all living things. The late Michigan peach crop this year has been a complete failure, and there are reports of similar crop failures throughout the country during the so-called epidemic. I do not wish to be quoted as saying that I attribute these crop failures throughout the country to a gas poison of definite composition. I have simply asserted the possibility and I am going to leave the theory of a gas-poisoned atmosphere to those who are well versed in chemical detection of gases and in geological science, to prove or disclaim what seems to me a plausible theory.

The disease which we are now combatting has been characterized by very rapid dissemination.

This rapidity, although beyond the limits of human conveyance, has been one of the dominant factors in terming it influenza. If, perchance, diarrhea was a prominent symptom, the term "Cholera" probably would have been substituted, and instead of an influenza epidemic we would have scared the population into a cholera epidemic.

Sneezing, coughing and spitting are the principal means of dissemination, we are told, yet large sections of Chicago and many suburban towns have escaped the epidemic. The distributing centers of infection in a large city during an epidemic usually is the crowded downtown district where people from all parts congregate. Yet it is significant that although all were equally exposed, the northern and southern portions of the city were the most seriously affected. This unusual distribution is not characteristic of a bacterial epidemic nor of contact infection. If by sneezing and spitting the atmosphere had become laden with germs (if these organisms are really the influenza germ, they being the smallest recognizable bacillus must be undoubtedly the lightest), it is natural to assume that they floated all over the city and a great diffusion of the disease should have occurred. On the other hand, a gas of great density with a clinging molecular composition would hang high during the day and low at night because of the slow nocturnal winds. Its clouds would not be so easily shifted, yet their distribution would vary with the wind currents, hence more circumscribed areas would be affected—as has been the case during this epidemic.

The apparent immunity or susceptibility of people to the disease depends on whether or not they come into contact with the gas. The weakened and diseased individual, the healthy and robust individual, the male and the female of the species, the young and the old, are all possible candidates if caught in the path of the gas. The severity of action, however, should depend upon the amount of gas absorbed, the state of health at the time and consequently the power of the body to neutralize its effects, but, paradoxically, that the "weak die first," has not been the rule in this disease. Indeed, the greatest number of its victims have been big, apparently strong, well-nourished persons.

Previous to the heavy rain fall, members of

the fire department were ordered to sprinkle the streets at night in order to keep the dust down, it being the prevailing idea that a settled dust would prevent the further spread of the disease. One hundred and twenty members of this "dust squad" became victims of the disease during the three days that followed.

There are no predisposing factors as far as sanitary conditions are concerned, since it has caused considerable worry to our more fortunate wealthy brothers living under favorable sanitary conditions.

The mode of transmission is undoubtedly through the agency of the atmosphere, hence I do not believe that personal contact is responsible for such a rapid, irregular spread, when countries having slight relations with infected countries have been visited with the epidemic. Of especial interest are the outbreaks occurring among the Eskimos of the far north and the natives of Patagonia in the far south.

The pathologic phenomena involve not only the respiratory tract but also the alimentary, vascular and nervous systems. Involvement of these systems seems to occur during part of the entire course of the disease and with such constancy that it is impossible to recognize the three well known clinical types of influenza.

The irritating substance which gains entrance into the body either through the nose or the mouth produces in its wake a hyperemia the degree of which depends upon 1. the quantity of the irritant absorbed 2. the condition of the system at the time of absorption.

If the irritant has been taken through the nose the lining of that organ becomes hyperemic and a decided coryza may result. In the great majority of cases however, the catarrhal condition is absent and replaced entirely by bleeding of the nose.

The upper portion of the tract including the buccal cavity, pharynx and soft palate are then affected and as the cause spreads downward hyperemia of the trachea and bronchi occur although the smaller bronchioles and grosser structures of the lungs seems to escape during the course of an uncomplicated case.

The severe tugging in the chest complained of by the majority of patients seems to be due to a greater degree of hyperemia at the junction and

bifurcation of the trachea and large bronchi due to the mechanical resistance offered at that point.

The irritating substance seemingly affects the pneumogastric, causing nausea and vomiting, especially as the esophagus seems to escape the hyperemia, there being no clinical evidence of such involvement.

I am of opinion that a simply, chemic, non-bacterial hyperemia in different degrees of severity is the initial structural phenomenon to which many secondary changes owe their origin. This is the nucleus, the starting point for bacterial invasion; because of the action of the irritating substance upon the tissues the hyperemic parts are damaged to a varying degree and suitable conditions for bacterial growth become established.

I repeat that chemic hyperemia is the cardinal, initial pathologic change. If slight, no further changes may occur excepting those produced by the absorption of the gas. On the other hand, if considerable, edema of the larynx, trachea, bronchi and of the lungs develops. Death may ensue from exhaustion or edema of the lungs and not to an extensive bronchitis. The considerable engorgement of vessels of the neck and the severe haemorrhages which occur in some cases are due to the mechanical exertion caused by the edematous condition of the lungs and not by any pneumonic inflammation.

In all cases the poison and the secondary bacterial toxins seem to affect the nervous system giving rise to a general constitutional breakdown and a rapid lowering of the vitality. It is during this period that inflammation of the bronchial tubes become dominant. The middle ear, frontal and ethmoidal sinuses may become involved by extension. The sputum is mucopurulent and of a grayish yellow color, and bacteriologic examinations in all cases proved to be negative for the Pfeiffer's bacillus. Occasionally the sputum is tinged with bright red blood which is due to the congestive state of the respiratory tract. As a matter of convenience the cases may be grouped under two heads, 1. a non-febrile type, characterized by the absence of fever providing no complications develop; 2. the febrile type, characterized by rapid rise in temperature which may be due to the absorption of the gas, changes directly

associated with the initial hyperemia or to complications.

The most pathognomic sign is a *furred tongue*. This you will find to be very constant and occurring not only in those who are already sick, but in those who are likely to be attacked. It seems to appear one or two weeks before the onset.

The furred condition is chiefly located in the posterior part and extends anteriorly. At first it is of a peculiar yellowish-brown or white; later in the course of the disease the color becomes dark brown with a yellowish-green tinge and will not respond to the usual treatment for gastric disturbances.

During the examination of conscripts I have made a point to determine the condition of the tongue. In one group of twenty-five men examined I was able to detect the furred tongue in eighteen; in thirty-four men examined thirty-two showed furred tongues; in forty examined twenty-eight showed furred tongues; the grade of coating varying with atmosphere conditions. Recently I was able to record fifty-four furred tongues out of fifty-seven examined. On this day the atmosphere conditions seemed to be very depressing. The day was dark and gloomy and a heavy, cold mist hung over the city.

I shall refer here to other symptoms in a general way as time will not permit of extensive descriptions, but I wish to emphasize the fact that the furred tongue is the best indicator for the general practitioner, and I believe that if stress were laid on its significance and a general adoption of "have your tongue examined" were instituted among the populace with the object of warning the individual showing a positive picture that the prevalence of "Flu" would be markedly reduced.

The general symptomatology may be ascribed to the effects of direct absorption and to secondary changes. The greater number of my cases have been of the afebrile type. When fever is present it is generally regular, rising to 100 to 102 degrees in mild cases and 103 to 104 or 105 degrees in severe cases. In the absence of complications the fever should not be regarded as a death sign as it usually responds to active treatment and subsides within three days after such treatment has been instituted. In some cases pains and soreness are general throughout the

muscular system, especially in the joints and lumbar region. This generalized soreness is not encountered in all cases. A tugging, oppressing pain over the chest and a feeling of depression and pain over the stomach, often described as a "ton of lead" feeling are constant and important features in the diagnosis of this condition. Headache, if present, is of the frontal type and very severe in some cases. Nose bleed is met with, in some cases coming to my attention. The onset of a great majority of cases is characterized by dizziness, nausea and vomiting, especially after a hearty meal, most of these cases are in robust health and show no apparent signs of disease.

If the disease we are now combating really is influenza, I must say that the symptoms are atypic and the bacterial cause of the disease is obscure.

The dizziness, the frequent nausea and vomiting, the pain over the stomach, the hyperemic condition of the tubes, the absence of initial fever, the abruptness of the attack, the failure to find Pfeiffer's bacillus, the response to early treatment are all in favor of a chemical toxemia and not a bacterial infection.

In regard to the prognosis, if the case is brought to your attention early, there is no cause for worry providing you immediately relieve the mind of the patient of the dread of the influenza and resort to immediate treatment of the symptoms in a plain, intelligent manner. I have had no loss from influenza or pneumonia as the records will show, but I have insisted that my orders should be strictly followed.

Influenza at present is the fad, but do not let the fad get you. No matter whether it is an ingrown toe nail, trench foot, delirium tremens, the mechanical sentence comes out, "You have got the Flu." I saw a man recently who had been suffering for years from a kidney stone; on his arrival home, his family physician, who was summoned, on hearing of the aching pains in the back, pronounced it "Influenza." The family was not satisfied because they were accustomed to the old chronic pain, so another physician was called and a confirmation of the original diagnosis was made. After stopping his so-called influenza pain with HMC, I recorded him in my books for an early operation.

I could mention many more instances of snap

judgment, influenza diagnosis, and I wish to state this "Flu" had lodged so deeply in my own mind that it was difficult to release myself from the prevalent obsession.

I believe in giving the devil his due, hence permit me to say that the increase in the number of reported cases was due to this fad. We got into the habit of calling everything the "Flu" and we failed to recognize anything else within the realm of medicine. The number of cases reported was exaggerated hence, the early statistical records of the "Flu" epidemic are not to be relied upon.

In regard to the treatment; if the tongue is characteristically furred, order the individual to bed, tell him to rest, take it easy, avoid mental and physical exertion and above all relax his mind. If he is to develop the condition you have prepared his system for the attack. If he is not on the list for an attack you still have accomplished something. The present condition of business, the political issues at hand and the anxiety which war and peace have caused, have increased the nerve tension and blood pressure of every thinking, active American; hence he needs rest on general principles.

I have had very little experience with vaccines in prevention or cure. As a practitioner, I wish to say, quick results are what we are after. I guard against the use of vaccines without resorting to other forms of therapy, although I am not unmindful of the scientific efforts that are being put forth in this direction. To expect to obtain immediate results in the use of vaccines is folly as they produce an active immunity, which takes about ten days to become established. What is to become of our patient during these ten days? Immunity produced by a vaccine which is made up of so many kinds of germs is not acceptable to me. If a specific germ draws a specific antibody from the body cells, then ten different specific germs must in turn draw ten specific types of antibodies. Can you picture a body cell to which are attached ten different germs each one asking for an antibody? "Some cell"—if it grants the request. The idea always has reminded me of the period when cruelty to human beings was indulged in for the sport of kings. Just think of a human being, tied to ten horses, each pulling in a different direction and claiming a certain portion of the body.

Now I will describe to you the method of procedure which I have adopted in the treatment of cases coming under my observation. The first thing I insist upon is absolute rest in bed, for at least five days. I always add "Unless you want to join the Kaiser and the devil by having crepe on the front door." This stirs the imagination, and excites a willing disposition to follow orders. No food of any kind, liquid, solid or otherwise for forty-eight hours or more. Especially is this rule enforced if fever is present as food will only aggravate the fever and increase abdominal pains. As a matter of routine I order a saline laxative or Pluto water every morning to open the bowel. If this fails the lower bowel is immediately freed by administering a S. S. enema. It is advisable to keep the bowels open daily. This method of procedure will be found superior to drastic purgatives. I always impress on the patient's mind the great value of drinking an abundance of water. If lemonade, orange-juice or weak tea is agreeable these may be given. A warm sponge bath, two to three times daily, followed by a brisk rub with a Turkish towel, soothes the nervous system, reduces the fever and makes the patient feel refreshed and hopeful. Alcohol in bathing may be used but as this is scarce at present plain water will be found of equal value. Keep the patient out of the way of draughts, and I am of opinion that a closed room is better than an open one. It may be aired several times during the day. The windows should never be opened in the early morning or during the night. A small fire should be kept in the house to dry the air, but never have it so hot as to cause inconvenience to the patient. If headache is present and unbearable, to give temporary relief, I have found phenacetin may be administered without danger of inducing delirium, providing small amounts are given and its use discontinued within a few hours.

If fever is high and constant, acid acetyl sal may be given for the first or initial doses to cause a general sweating and to reduce the temperature; this, however, must not be given for too long a period.

As the inflammation develops in the respiratory tract I have used the following with especially good results. Rx. Calcidin, grs. one; Sodium Salicylate, gr. three, in capsul or mixture. This is given continuously every three

hours until the fever abates. The dosage of this mixture is regulated to suit the age of children, in whom I have had excellent results. I believe starvation is better than feeding the patient. I have been able to allay the most severe and treacherous rise of fever by adhering to hydrotherapy and starvation, etc.

Should cough become severe and a sense of tightness, soreness and tugging develop over the chest a counter irritant is indicated and should be immediately applied to abort the bronchial inflammation and to prevent any chance of secondary pneumonic congestion.

For a counter irritant I prefer the old fashioned mustard poultice applied lengthwise from the larynx downward to the stomach. It should be left on until it becomes unbearable. This should be again resorted to at any time during the course, if indications arise for its use. It is a good routine practice in all cases having fever, to recommend the use of a cotton jacket and camphorated oil applied to the chest. Counter irritants, withdrawal of blood, and saline transfusion may be resorted to where necessary. When the temperature becomes normal the sodium salicylate is discontinued. However, the use of calcidin is kept up and as a tonic strychnin is added. This seems to do more good for the general weakness and debility that follows than do alcoholic beverages. After a few days the patient has regained part of his former strength and appetite, I find a meal of rare steak seems to be preferred to any other sort of meat.

I am of the opinion that all cough sedatives are contra-indicated. Do not stop the cough; give expectorants to loosen the secretions and allow Nature to eliminate it. To stop the cough is to stop expectoration and increase the chances of a complicating pneumonia. Calcidin loosens the secretions; give it freely.

The course of the disease is variable, but I have had no cases showing active symptoms after the fourth day of treatment. Friends who have resorted to this method of handling their cases have reported to me that the duration of active symptoms had been the same.

In conclusion, permit me to say that quick and sensible recognition of the condition, the immediate ordering of the patient to bed, and an early, regular and progressive line of treatment will save most cases.

DISCUSSION

DR. LYDSTON: My interest in this subject is not special—rather general—but I have had the opportunity of seeing a few cases and witnessing a few postmortems on the victims of the so-called influenza epidemic.

Regarding the nomenclature, I presume that the appellation "Spanish Influenza" is due to the fact that the first epidemic that was recognized as influenza did originate in Spain, in 1824. But long prior to that time there occurred in Europe epidemics—as far back as the latter part of the 14th Century—of what was called the "sweating sickness" which some of our modern writers have supposed to be the forerunner of what we now know as influenza, not typic, as we knew it in the previous epidemics of influenza, not typic as compared with this recent epidemic of so-called influenza. This naturally would be expected from the fact that, whatever the origin of those epidemics may have been, the characteristics would not necessarily remain the same. This is apparent to anyone who believes that the evolutionary theory applies to micro-organisms as well as to other phenomena of organic life.

I do not believe that the fact that the phenomena of the recent epidemic did not exactly correspond to those of previous epidemics necessarily proves that they are not the same or at least were not the same in origin. History shows very positively that great wars have been associated with and followed by epidemics of various kinds and have shown, too, that there has been a variation in type of epidemics of absolutely similar origin.

The idea that some atmospheric influence, something dissociated from the germ explanation of infection or of epidemics in general, underlies such epidemics as this recent one of alleged influenza was, as some of you may recall, promulgated by Wagner many, many years ago in his work on pathology under the caption of "The Epidemic Constitution of Disease."

I think that sometimes we possibly are greatly at fault, speaking in an unconventional way, in picking out a three-cornered disease, seeking a three-cornered germ to fit it, then hunting for a three-cornered club to kill it with and forgetting many of the excellent ideas that our medical forefathers promulgated and some of which were very, very sound and practical.

I remember being very strongly impressed by Wagner's observations on the epidemic influence in disease and I always have felt that much that he said was sound and perhaps might well be remembered by all of us who consider ourselves modern and up to date.

Now the view that some chemical constitution of the atmosphere underlies the recent epidemic would be very hard to disprove—quite as hard as it would be for Dr. Croft to prove it. Almost as hard to prove as the popular notion at the City Hall that tobacco spit is the cause of influenza.

Even admitting, however, that some peculiar chemical constitution of the atmosphere is the basis of such epidemics as that we have just gone through,

does not disprove, necessarily, the importance of germs of various kinds in the pathologic complex that we know as influenza. Dr. Croft himself inadvertently admitted that in the course of his paper. He admits that the fundamental cause is some peculiarity of constitution of the atmosphere, then proceeds in the next breath to show that in the course of the disease, mixed infections of various kinds develop with consequent pathological phenomena.

Dr. Croft thus has admitted the importance of germs. This, of course, does not necessarily prove that we are in a position to cure the disease or prevent it by any kind of vaccines—nor does it disprove it.

I occupy something of middle ground on the vaccinal therapy proposition. I believe that in vaccines we have a very valuable therapeutic resource, but I think that as yet we are just on the threshold of our knowledge of vaccines in the treatment and prevention of disease. I fancy that, as times goes on and we understand more thoroughly the selection of the proper vaccines and the dosage of administration and the conditions under which they should be administered, some of us possibly may have more confidence in vaccines than we have now.

On the other hand, I have suspected that sometimes vaccines are chiefly valuable in keeping the surgeon or physician busy and the patient amused while nature is taking care of the disease. I suggested to one of my friends today that the best treatment of acute gonorrhea was vaccine. He said, "What kind?" I said, "Made out of sterile distilled water."

Doctor Croft brought out some other rather interesting points in connection with the morbid anatomy of the disease. He laid stress upon edema of the bronchi and edema of the lungs as one of the important factors. In the few cases that I have seen postmortem those happened to be the predominating factors. Whether the cases were typic or not I am not prepared to say, but they certainly presented the same characteristics that a large proportion of them do in postmortem.

In viewing these postmortems I was unable to see much difference between the so-called patchy pneumonia that develops in connection with the pulmonary disturbance of the so-called influenza and what we used to call lobular pneumonia. I think most of the consolidated areas are what we used to call atelectasis and the true lobar pneumonia that develops, it seems to me, is a sequence rather than a characteristic of the disease itself.

Reverting to the edema, I think it was Dr. Richardson of Boston who, in connection with a postmortem on a "typic" case (or what he termed a typic case) of this so-called influenza said, "These patients drown; they simply drown. The hemorrhagic edema of the bronchi and the pulmonary structure is the cause of death."

We can easily understand that the other phenomena that occur, the cyanosis of the skin from imperfect oxygenation, hemorrhages, etc., might rationally be explained by the obstruction of the lungs produced

simply by the hemorrhagic edema. To me, however, the hemorrhages seem to be due to two things, viz: First, the purely mechanical conditions present and Second, to toxemia. I have had occasion to see in consultation several cases of hemorrhage from the kidney and bladder occurring as a complication in the course of influenza so that I speak advisedly on this particular point.

The one thing that has impressed me, gentlemen, in this epidemic is this: If there ever was a panic-stricken lot of people in the world it has been the medical profession. It seemed to me that we took it for granted that, in as much as we had no specific vaccine, we were at the end of our Latin and the patient either died or got well in spite of us. Thus we became fatalists. I think most of the general practitioners who were thus panic-stricken forgot that they were pretty good doctors before influenza ever was heard of.

Now if we are going to be panic-stricken in epidemics such as the recent one under consideration, and forget the sound, rational principles of therapy that we apply in other conditions, we certainly are not going to improve the mortality record and I believe that you all know it to be a fact that the profession in general has been pretty panicky in the course of this epidemic.

Some of the edicts and some of the advice and wisdom that have emanated from the Health Department is very suggestive of panic. I presume it might be argued now that because smoking was prohibited upon the street cars and elevated and railroad trains it is easy to explain why the epidemic has subsided.

Of course, the facts that first an epidemic does not necessarily hit the entire community but may spread in waves and perhaps circles that extend a certain distance and then stop and diverge in some other direction; and second, that an epidemic picks out those that are susceptible and misses those that are primarily immune and third, that having picked out all the susceptible ones and killed off all those that could not resist, the epidemic after a while stops—would be no argument with some people.

It is suggestive along the lines that the Doctor has outlined here this evening, that they are having upon the Pacific Coast—in Los Angeles for example. California is supposed to have a wonderful climate (in fact, we native Californians claim there is nothing in the world like our California climate and we don't want you to say that it does not cure everything, or better, prevent everything), but all the same they are having more trouble in Los Angeles than we have had in Chicago.

One point that might have been brought out with reference to the contagiousness of this disease is that it moves rather faster than people move. It moves rather faster than could be explained by contagion in the ordinary sense of the term. It takes wonderful jumps. For instance, I heard from some friends of mine in the East the other day who were living on a little farm very remote from any populous center, people who were not in the habit of going to the

city at all but just lived in an old-fashioned, Yankee, New England way on that farm, that the husband and wife were attacked with influenza and that the wife had died. There was no possibility, so far as could be learned, of any contact with any cases that would have afforded contagion.

Now we have innumerable similar examples and it seems as though the theory of contagion does not explain it at all. Whether we can prove that some influence in the atmosphere explains it is an entirely different proposition. That some occult atmospheric condition exists that produces a lack of resistance, and a susceptibility to such conditions as the recent epidemic of influenza, or whatever it may have been, is quite likely but it would be a difficult thing to prove.

It is not surprising that epidemics should arise in Army camps. It is stated that our soldiers are taken such excellent care of, housed, fed and clothed so well that the conditions in the camps couldn't possibly explain it, but, all the same, the "crowd influence" is a very important thing in all epidemics and it is something that we should not lose sight of.

Laying aside the crowd influence in the case of Army camps there is no use saying that they haven't had considerable trouble. A surgeon friend at Camp Devons, Massachusetts, said to me, "We are just simply over-run with it down there. There were 7,000 cases when I left, with pneumonia galore."

Now, that was a pretty serious proposition. That meant 7,000 cases just at that time; which meant that there must have been an inordinate number of cases during the prevalence of the epidemic. The Government issued reports to the effect that: "We have this under control; we've got it licked out." The Health Department said we had it licked out in Chicago. Yes, a fire is "licked out," too, when it has burned up all the fuel, and it is just about as sensible to say we licked the fire out, after everything is burned up, as to say we licked out this epidemic. It burned itself out. So it was with the "flu" in the army camps!

To revert to the excellent treatment of our soldiers: A human being is very much like a tree. You remember that landscape gardeners, at great expense and bother, planted a lot of trees down in Grant Park—trees pretty well grown, very expensive trees, that cost the city a good deal of money. It was said that the gases from the Illinois Central locomotives killed those trees.

Those of you who saw the filling in of Grant Park knew something about the soil. But there is something else. If those trees had been seedlings, costing about two cents apiece, had had a little black earth planted about them and had been kept properly irrigated, most of them would have lived and we'd have had some foliage down in Grant Park now instead of a desert waste.

Any gardener will tell you that a little bit of a tree, changed from the environment in which the seedling grew, will do much better in a strange environment than will one half-grown. Why isn't the same true of the human being? The Government may be perfectly satisfied with the way it treats its soldiers, but they

are not living under the same environmental conditions as at home.

Think of how many of them have lived in heated houses, furnace, steam, hot water heated houses. Look at these Jackies on the streets with their low cut blouses, without overcoats, when a light overcoat is very comfortable to the rest of us, and I think you will see the point.

They haven't the same food, they are crowded; there is the element of contact, intimate contact with others. You remember at the beginning of the war they were putting about eight men in a tent when they should have had two or three, until Gen. Gorgas finally decided that they needed more space, that a soldier needed quite as many cubic feet of fresh air as did the average citizen.

Now, under these conditions it is reasonable to suppose that germ life would be likely to thrive. Germs that were previously innocuous would not only thrive and wax fat and multiply, but would acquire new properties.

Therein lies the chief weakness of the Doctor's chemical view of the etiology of influenza, because, no matter what the primary cause may be, once the soil is changed, the germ changes, multiplies very rapidly, and adapts itself as fast as may be. If it does not adapt itself it dies. By and by you have an intense cultivation of organisms that possibly may carry contagion, may even have specific pathogenic properties. These things really are worth considering.

I firmly believe that all of our epidemics, as far as we can go back into history, are explainable on a purely evolutionary basis. I never believed in the specific origin of any germ whatsoever. I don't believe in it any more than I believe in a specific creation of any organism whatsoever.

I don't believe that germs were created at all, much less at any one particular time. If we accept the theory of specific creation of germs we must accept the specific theory of creation of all animal and vegetable organisms and, beginning with Adam and Eve, we will recall that the only habitat for certain diseases at that time would have been the systems of Adam and Eve.

Now, as gonorrhea is a purely human disease and chancroid is a purely human disease, and syphilis is a wonderfully humanized disease, and leprosy, scarlet fever and measles, and a few other things are human diseases, Adam and Eve must have had a lovely time.

As syphilis and gonorrhea are not particularly favorable to fertility, we can easily see that, according to the theory of specific creation of disease, not only are we not here, but our forefathers never were born, because Adam and Eve must have been sterile.

It is not for me to comment particularly on the therapy that Dr. Croft has outlined. There is a lot of common sense in it. I would, however, take exception to his view that the proper way to get the fear of the "flu" out of a man was to throw another scare into him.

The thing that impressed me most regarding his therapeutics was a lot of common sense that every general practitioner should have. Now, the general

practitioner does not always put into practice what he really knows. He does not always take the best advantage of his own practical knowledge and experience, especially if he is in a panic. Because he does not know the specific cause of a disease, because he does not know any specific organism as the cause of the disease, or any specific remedy to kill that organism once he finds it, is no particular reason why he should lie down and forget to treat the patient for what ails him.

I wish to reiterate what I said about the morbid anatomy of these cases, the so-called typic ones, and especially with reference to the hemorrhagic edema and the patch pneumonia. As I stated, I can't see any difference between that and what we call lobular pneumonia, with the exception that there is a greater tendency to hemorrhagic areas here and there than in the ordinary type of so-called broncho or lobular pneumonia, and I firmly believe that the mechanical condition is essentially the most severe and important condition with which we have to deal.

The fact that these cases either die or get well very quickly, that there is not a particularly prolonged period of convalescence, even though they are left weak afterwards, is suggestive that there is some condition other than a secondary bacterial toxemia underlying the pathology.

DR. O'CONNOR: I was more than glad when the opportunity presented itself through Dr. Croft's request to make a bacteriological survey of his cases having previously entertained the desire to study the etiology.

In the way of a summary I wish to state I selected 300 sputums, so that I had practically an even amount from cases with and without fever, but with the general signs of weakness, pains in back and stomach and tugging in the chest.

The sputums were all portions of 24 hours expectorations and were muco, muco-purulent and occasionally tinged with blood. Two direct smears were made of each sputum, one stained by the dilute fuchsin method and the other by Gram's method, using Pyronin methyl-green. Culturally, three implantations were made, two on pigeons' hemoglobinized agar and the other on human hemoglobinized bouillon. In each instance, a number of suspicious lumps in the sputum were placed in sterile water and shaken in order to break them up previous to the inoculation process. One-tenth c.c. of this sputum water was added to each bouillon tube and to one pigeon hemoglobinized agar plate. A slanted agar tube containing pigeon's hemoglobin was inoculated with the pure sputum. In all of these inoculations no bacterium of the morphological characters of Pfeiffer's bacillus were found. A control inoculation of the above medias with a known culture of the Pfeiffer's bacillus gave excellent results. Guinea pig inoculations of over 25 cases were negative.

DR. LILLY: The treatment that we used at Mercy Hospital was in contradistinction to Dr. Croft's method. We resorted to "fresh air." Before pneumonia complication set in we gave small doses of aspirin, phenacetin and quinin. All were well fed, not

starved according to Dr. Croft's method. We gave liquor terpin hydrate and codein to allay annoying cough. Stimulants were given for pneumonic signs and cardiac failure. The mortality has been very high at Mercy Hospital during this epidemic.

DR. GREGORY: I have used same method of procedure as Dr. Croft in treatment, but as a purgative I used castor oil. Have had good results in over 600 cases without mortality.

DR. LEONARD: I believe that in all febrile toxic conditions elimination is the keynote, whether you eliminate with castor oil or whether you do it with a good expectorant or anything else.

Dr. Pechous seemed to believe that there is a plausibility in Dr. Croft's gaseous theory.

DR. SCHNEIDER: As health officer of Winnetka I noticed the disease developing about the second week of September, three days after the first case at Great Lakes. Twenty of our cases are traceable to that source. From that time the disease increased and spread rapidly in our neighborhood. All public health measures were adopted. An interesting point is that leukopenia is always marked.

Dr. Rogers conducted numerous experiments on animals for the Government. His conclusions are that the old classical understanding of inflammation as a reaction of tissues to an irritation is absolutely worthless.

Dr. Graves stated that he saw cases where the Health Department had given the vaccine and they later developed the disease.

DR. PENCE: Atmospheric conditions may play queer pranks, possibly many more of them than we are aware of. We all know that on certain days of freak weather nearly all of our patients are not so well. Tuberculous patients respond to weather conditions very markedly. All of us see our chronic asthmatics labor for breath during atmospheric changes. Rheumatic patients are notoriously grouchy during weather fluctuations. That pneumonia patients do badly on certain days has been recorded.

In connection with the topic under discussion, it is of interest to me to recall an incident happening recently to plant life. A few months ago the West Park Board was preparing for a begonia show. The gardener had reared a large number of excellent specimens—the finest they had ever raised. The plants were just ready to be placed on exhibition and were to be moved the next day, when a night of intense fog came on. You will all remember the three or four days of very intense fog occurring a few months ago. The morning following the first severe fog every plant had turned black and wilted to the ground. I think not a single plant escaped. This catastrophe was ascribed by the superintendent, whether rightly or not I do not know, to atmospheric conditions—to gas escaping from the many soft coal furnaces, drifting to the western side of the city with an east wind and settling to the earth. At least, the tender begonia foliage had been withered and blackened in a few hours.

This, of course, adds no light on influenza, but it does demonstrate atmospheric conditions can destroy plant life very unexpectedly. If atmospheric condi-

tions can arise which will destroy certain forms of plant life, it is not unreasonable to suppose that similar atmospheric conditions may be a very strong predisposing factor in the causation of respiratory disease epidemics.

In regard to the peculiarly "furred tongue" which I have noted as apparently premonitory of so-called influenza, I have observed the same phenomenon in a large number of individuals whom I have been unable to follow up with reference to subsequent conditions.

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ROBERT J. FOLONIE.....	39 S. La Salle Street, Chicago
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State society will pay no bills for legal services except those contracted by the Committee. Notify the Chairman at once. Do not employ attorneys.

JANUARY, 1919

Editorial

THE COMING YEAR'S WORK.

At the beginning of this new year one can scarcely refrain from indulging in thoughts of both past and the future. It is a time for casting of accounts.

The world war has taken its toll from the profession just as it has from the ranks. An unusual number of brilliant medical men have crossed the great divide. Many promising business practices have been sacrificed, and generally the profession has been hard worked. The world has been jostled as it never was jostled before, and no science, art or industry has been more jostled and upset than has the medical profession.

When we as individuals have again assumed our normal poise, and have readjusted our affairs to fit in and coincide with future conditions as they may arise in accordance with a post-war era, we must then as a profession, as an organized profession, give our attention not only to those things which are of importance to mankind, but also to those things which are of vital importance to the profession.

The societies of specialists will in a very large manner take care of scientific medicine, although it is the duty of organized medicine to encourage and aid the interests of that science. Organized medicine must serve two functions: first, the function of encouraging, stimulating and creating medical science, and, second, it must strenuously guard the rights and economic interests of the profession.

In these days of multiple welfare associations, of over-zealous health officers or public health departments, of so-called state medicine and other quasi-health functionaries, the public will suffer many wrongs and injustices, and the profession will be used as the proverbial "free horse" and scapegoat. It is already being used largely as the "free horse."

The mismanagement of the quarantine regulations in many places during the present influenza epidemic indicates the necessity of the profession taking a more decided interest in such matters. It would indicate that perhaps health matters, especially in the larger communities, should be in the hands of a board composed of several members of the profession, rather than in the hands of one individual.

The question of state medicine already appearing on the horizon is a subject for the organized profession to ponder. Before the next legislature will be placed the iniquitous plan of compelling physicians to register annually and pay a fee for so doing, thus making them carry a financial bur-

den of supporting the Board of Registration and Education.

Another vicious bill in some form will go before many of the state legislatures soon, asking for compulsory health insurance. It has proven a failure in other countries and is quite generally condemned by the profession. It is another German paternalistic method, fomented and espoused principally by so-called welfare workers, and is not wanted by the employee, the employer, the profession or anyone else responsible. However, the bill will be strenuously pushed, and it will remain for the profession to fight it or carry much of the burden.

There are many problems which must be solved by the organized profession, such as that of medical education, reciprocity between the various states, standardization of medical colleges, standardization of hospitals, the proper division of fees paid for joint services, and many other perplexing questions. All of these cause us to speculate on the future. If these and other problems are not solved in a manner dealing fairly with the profession, sooner or later the stimulus for medical men will cease, and just so far will come medical decadence. Nothing, we believe, could kill the interest in the study of medicine more than would the adoption of state medicine. We are not afraid of state medicine being adopted all at once, but the tendency is drifting toward us, or rather is being pushed toward us by these several agencies. Most of these problems are not of especial menace to the men of some years in practice, but are surely threatening the status of the profession of tomorrow.

From the scientific side of medicine there are many perplexing, unsolved problems confronting us, over which the medical scientists at least will delve most strenuously, and on this beginning new year we can but speculate on the results of the coming decade. The war has interfered greatly with scientific medical study along many lines, adding much, it is true, to the advancement along other avenues.

The great enigma of medicine—the ductless glands—must be solved. We cannot boast much at the beginning of this new new year of our knowledge relative to their physiology or biochemistry. The relationship of the ductless glands to the renal-cardio-vascular system is still

in darkness. Our knowledge of the cancer problem has not advanced materially in a number of years. The many problems of immunity and infection are only guessed at. The death dealing work of the armies is over, and it now remains for the medical profession to salvage and restore to usefulness the greatest possible number of the wounded.

How much of all this work may be accomplished during the year now beginning is problematical, but the profession will be at it. While medicine is progressing, let us not forget that the profession of the next decade must live rightly in order to progress, and let us so work now that progressive medicine will not slacken its pace.

QUARANTINE RULES MUST NOT DISCRIMINATE.

The Supreme Court of Kansas has ruled against unfair quarantine regulations in a decision declaring the Board of Health of Wichita had exceeded its authority in ordering the closing of churches during the epidemic of influenza. The Board of Health ordered the closing of churches, schools and theatres and allowed departments stores and other crowded places of business, such as depots, restaurants and drug stores, to remain open. Eighty-seven persons were counted in one street car. A dinner for newsboys was also given which was attended by two hundred.

Justice Bird of the lower court granted the injunction, and gave his opinion that if conditions were such as to warrant quarantine, it was within the power of the health authorities to make a general order affecting all places where persons assembled, excepting such as are necessary for the maintenance of life, but that it was not permissible to discriminate, closing one organization or industry and permitting others to remain open. Justice Bird suggested two courses for the Health department to follow,—to enforce a rigid quarantine of all insanitary places or to prohibit all kinds of crowds above a certain number.

The city attorney appealed to the Supreme Court, maintaining that the district judge did not have jurisdiction. The Supreme Court sustained the lower court.

INFLUENZA STILL REIGNS

Influenza, while not so prevalent or so virulent, is still claiming first place in importance in public health matters.

It was hoped that at the recent meeting of the American Public Health Association held in Chicago some light might be thrown on this subject. The only result clearly proven was that we are still in the dark as to the cause and control of the disease. There was little unanimity of opinion.

The primary cause of the disease is not yet demonstrated. Its method of transmission is not known. Many of the measures taken for the control of the disease have not proven of value. Crowding people, as in military camps, has undoubtedly increased both the spread of the disease and the mortality. Quarantine has apparently been of little value because not generally or properly practiced. There has been no specific treatment found. It is hoped that our laboratory men will eventually find the exciting cause. Until such discovery the treatment must be purely symptomatic. General opinion is that we will have the disease with us in a rather severe form for many months, and this opinion is supported by the history of previous epidemics.

A special committee of the American Public Health Association made a report on the epidemic. The report is not at all satisfactory, but is the best it is possible to make at this time, and it should be read by all physicians. It is published in the *Journal of the American Medical Association* for December 21, 1918.

DO YOU WANT TO LOSE YOUR LICENSE TO PRACTICE?

The Department of Registration and Education of the State of Illinois intends to ask the State Legislature at the present session to enact a law which is to compel the physicians of the state to renew annually their licenses to practice, at a cost of two dollars. Failure to attend to such renewal within the allotted time cancels the physician's right to practice. The announced purpose of the law is to give the department the power to refuse renewal of licenses to those whom it regards as unfit to practice medicine, the measure being intended to drive quacks from the state and so protect the public from being injured or defrauded by them.

This proposed law contains serious objections in regard to the rights and liberties of the medical profession. Nevertheless, it was approved by the delegates of the State Society last summer, an action that would seem to stamp it as desirable until it is understood that the committee that reported it favorably to the house of delegates had had no time to debate the matter and was under the immediate influence of an eloquent address by the director of the department of registration, the subject in addition being presented to the house at the very end of the session when it had had no time to consider the objections to the law.

Contrary to what seems to be a general impression, the law is not intended for the protection of the *doctor's* rights, but is meant to guard the *public* from exploitation by quacks, therefore it is obvious that it is the public and not the physicians that should pay for its enforcement. It is evidently wrong that the honorable and respectable doctor should be fined two dollars a year as vicarious atonement for the sins of unscrupulous cheats who, with the tolerant approval of the state, have attached themselves as marauders to the great and noble army of our profession, which has not been protected as it should have been by the state against the rivalry of such parasites. Far from it, the state, while exacting the utmost in study, qualifications and responsibility from the doctor, has connived at and permits the inroads upon his prosperity by Christian Scientists, osteopaths, optometrists and all of the evil things we know so well and which are of infinitely greater injury to the public than the few advertising quacks and unlicensed practitioners that are to be hit by this bill.

The most important objection, however, to the law, as viewed by the doctor, is the power to deprive him of his livelihood which it confers upon a department composed of laymen. The law is for a long time. The membership of the board will be constantly changing. Well-intentioned boards will be followed by unfair ones. Seeing their chance to hurt us, the many active and vindictive enemies of the profession will make every effort to be appointed members of the Board of Registration and Education. While the law says that "the Director of Registration and Education and Assistant Director, and the Superintendent of Registration shall not be affiliated

with any college or school of medicine, pharmacy, dentistry, nursing, optometry, embalming, barbering, veterinary medicine and surgery, architecture or structural engineering either as a teacher, officer or stockholder, nor shall they hold license or certificate to exercise or practice any of the professions, trades or occupations regulated," there is, nevertheless, nothing to keep the many ardent lay followers of osteopathy, Christian Science or other organizations inimical to the doctor from membership in that board, and what havoc such followers could create with our right to earn our living may be imagined. Licenses could be suspended upon unfounded accusations of "unprofessional conduct" by angered patients or jealous rivals. Their word would be as good as ours. The term "unprofessional conduct" is a broad one and may be interpreted almost as suits the accuser. It is not defined in law as yet. What could the doctor do to regain his license? Only appeal to the courts and then await the end of the law's delays, while his practice would evaporate and his income stop. No matter how innocent, the doctor would be put upon the defensive.

"But," it may be said, "public opinion would not tolerate such injustice." How much legal and other injustice have you seen tolerated? Enough, probably, to make you averse to putting your head in such a noose as this new law would be. Since when has public opinion favored the doctor?

A proportionately lesser objection to the proposed law is the need of assurance that the license renewal fee of two dollars has reached the department. If you fail to register in time you lose your license. You have all of the responsibility of payment in time. It will be as in the case of the Harrison law. Failure of your dollar to reach the government before the date set, even if not your fault, is not accepted as an excuse; you must see that the tax is actually paid in time, or the government takes it for granted that you do not care to prescribe narcotics and you lose the privilege to do so. Similarly, you would have the anxiety in regard to your right to practice until you received your receipt from the department of registration.

The last objection is the indignity of the whole thing. Every year you would have to humbly appeal to a lay department, that has the right to

disbar you, for the right to use the knowledge to gain which you sacrificed the years of your youth. Your freedom would be gone. When you passed that state board examination you regarded the right obtained as a right for life. If the law is passed, this right will expire annually, and you will have no control over its renewal. Must, indeed, the whole profession be placed in bondage to punish a few quacks, while the "healers" practice unmolested and irresponsible? The profession of the state must fight this law.

The right way to combat quackery and unprofessional conduct on the part of wrongdoers in the medical body is to empower that body to itself regulate the conduct of its members by control of their licenses, and, if need be, dismissal from the profession if a trial show their unworthiness. The bar association thus regulates the conduct of its members and it is not subjected to the control of a board of non-lawyers. To give us this power would be to treat the medical profession with respect. To pass this law is to insult it.

Looking backward, it is evident that assaults on the rights of the medical profession have increased enormously since the year 1880. Since that time all of the numerous cults that are encouraged by the public to rival us have come into being. Imagine a time, and there was such, when there were no osteopaths, no chiropractors, no psychopaths, and, above all, no Christian Scientists to oppose us. Now, as if it were not enough that we must face such dastardly competition, legal regulations are being constantly created to hamper and harm us. We are threatened with health insurance and, as the editor of this journal has so ably set forth in the December number, in addition to the dispensary abuse, we are to have the rightful earnings of the profession curtailed by free treatment by the state of venereal disease.

Truly the entire profession must take up the fight to protect its endangered rights as it never did before.

OTTO T. FREER, M. D.,
Chicago.

SANATORIUM TO BE DEDICATED

The La Salle County Tuberculosis Sanatorium—first of a chain of forty similar institutions to be built in Illinois during the next eighteen months—is to be formally dedicated Sunday, February 2.

The dedication program is to take place at the sanatorium, which is located on the outskirts of **Ottawa**. Members of the sanatorium board, which is made up of Dr. K. W. Leland of Utica, Rev. John P. Quinn of Ottawa, and Mrs. Fred LeRoy of Streator, will hold open house at the new institution during the forenoon. Visitors will be shown through the entire institution and will be supplied with complete information concerning construction costs and other points of interest.

The formal program will begin at two o'clock in the afternoon, with Dr. George Thomas Palmer, president of the Illinois Tuberculosis Association, as presiding officer.

Addresses will be given by Dr. David Lyman of Wallingford, Conn., president of the National Tuberculous Association; Dr. C. St. Clair Drake, director of the Illinois State Department of Public Health, and others. A pleasing feature of the dedication will be the unveiling of a bronze tablet commemorating the event.

At present, the new sanatorium consists of three buildings—a brick administration building, with facilities which will permit of an expansion of the institution to more than double its present size; a pavilion for early cases which will house from twenty to thirty patients, and a pavilion for bed cases which will house fourteen patients. Ample dressing room, locker room and toilet facilities are provided in both pavilions.

A survey of La Salle County, made during the period while the sanatorium was under construction, revealed the existence of approximately 600 cases of tuberculosis, and it is believed that the new hospital will be taxed to its present capacity soon after it is opened.

Officers and members of the Illinois Tuberculosis Association who have been active in the movement for new county tuberculosis sanatoria throughout the state are expecting a large attendance from Illinois, Indiana, Iowa, Wisconsin and Michigan. Doctors and nurses interested in any phase of the tuberculosis problem are especially invited.

TWO JOURNALS IN ONE MONTH

A few weeks ago we received an announcement from the *Medical Review of Reviews*, advising us that they had just purchased the *Buffalo Medical Journal*, which was to be consolidated with their own publication in January.

We are just in receipt of another announcement from the *Medical Review of Reviews* advising that they have also purchased *The Southern Practitioner*, which will also be consolidated with the *Review* next month.

This is the fourth journal which the *Medical Review of Reviews* has purchased and consolidated under its present management, and certainly speaks well for the continued success of this publication.

The *Medical Review of Reviews* announces that it hopes to purchase still other medical journals, and will pay cash for any that are for sale.

Correspondence

OUR HEALTH INSURANCE COMMITTEE COMPLIMENTED.

Cincinnati, Ohio, Dec. 22, 1918.

Chairman and Gentlemen of the Health Insurance Committee of the Illinois State and Chicago Medical Societies:

"Some days ago I attended the meeting of the Ohio Commission on Compulsory Health Insurance. Your pamphlets were quoted and read as of the first authority against the idea of establishing Compulsory Health Insurance in America."

Very sincerely,

H. S. SPALDING, S. J.

Public Health

MORTALITY FROM INFLUENZA-PNEUMONIA IN THE LARGER AMERICAN CITIES

Official Figures Show Cities of Central West Have Lowest Death Rates

Official figures of mortality from influenza-pneumonia for the leading cities of the United States, recently issued by the Federal Public Health Service for the period from September 14 to December 21, 1918, afford the first accurate information that has been available and corrects impressions and statements which have been given wide publicity during the past few weeks. While all of the facts relative to the epidemics in these cities and the restrictive methods employed are not fully known at this time, the published reports have given general information which make some of these figures at least suggestive.

In order of lowest mortality the cities of the nation with population over 300,000 make the following showing:

City	Estimated Population	Influenza- Pneumonia Deaths	Death Rate per 1,000 Pop.
	July 1 1918		
Minneapolis	383,442	925	2.41
Milwaukee	453,481	1,274	2.81
St. Louis	779,551	2,851	3.65
Chicago	2,596,681	10,309	3.97
Los Angeles	568,495	2,277	4.01
Cleveland	810,306	3,345	4.13
Cincinnati	418,022	1,800	4.31
New York	5,215,879	22,974	4.40
Newark	428,684	2,083	4.86

Buffalo	473,229	2,449	5.18
San Francisco	478,530	2,505	5.23
Kansas City	313,785	1,682	5.36
Washington	401,681	2,329	5.80
New Orleans	382,273	2,313	6.05
Boston	785,245	4,788	6.09
Baltimore	599,653	4,012	6.68
Pittsburgh	593,303	4,399	7.41
Philadelphia	1,761,371	13,375	7.60

Considerable attention has been directed to the exceedingly low death rate attributed to the city of New York in connection with the employment of the minimum of restrictive measures. It will be noted that New York stands eighth in this list and, while not in any sense conclusive, it is also noted that in St. Louis, where the restrictive measures were very rigidly applied, the death rate was 3.65 per 1,000 of population; in Chicago, where restrictive measures were moderate, the rate was 3.97, while in New York, with its minimum of regulatory measures, the rate was 4.40 per 1,000.

Philadelphia is accorded the highest mortality rate with Pittsburgh, Baltimore, Boston, and New Orleans coming next in the order named.

STATE DIAGNOSTIC LABORATORIES

The Division of Diagnostic Laboratories of the State Department of Public Health announces that from January 1, 1919, Wassermann tests will be made without charge for all classes of persons regardless of their financial condition. The laboratories have made these tests without charge for indigent persons for some time past.

After a very heavy increase in work during the past year, the demands for laboratory service have fallen off materially, during the past few weeks. It is believed that this unusual situation has been brought about by the widespread prevalence of influenza and the excessive demands upon the physicians of the state and also by the notable decrease in diphtheria and other communicable diseases.

LOW INCIDENCE OF COMMUNICABLE DISEASES OF CHILDREN

The reports of the Division of Communicable Diseases of the State Department of Public Health show an incidence of scarlet fever, diphtheria, measles and other communicable diseases of childhood lower than has been recorded in Illinois at this season for many years past. This low morbidity from such diseases is particularly noticeable in the central and southern sections of the State, the only exception being in Chicago and Cook County where diphtheria prevails to about the average or "normal" extent.

The cause of this small number of cases of communicable diseases among school children is, of course, open to discussion; but it will be noted that this decrease comes just at the time when Illinois communities have been more or less panic-stricken by a tragic epidemic of influenza.

The rules of the State Health Department require

that, in the presence of influenza, schools must be closed unless medical school inspection is carried out by physicians or school nurses are employed. While the manner in which this requirement has been carried out in some communities has been little short of a travesty, it is found that in most of the towns and cities medical inspection is being performed intelligently and in good faith. At any rate, the school children of Illinois have been under much closer medical supervision than ever before in the history of the State. It is quite reasonable to assume that, on account of this medical inspection, cases of communicable disease are being detected early, the victims of these diseases being sent to their homes and isolated at once and the degree of exposure thereby tremendously reduced.

The fact that Chicago and her suburbs have not shown a similar decrease is perhaps due to the fact that that section of the State has had medical school inspection for some time past.

As an interesting beneficial by-product of the influenza epidemic is noted the large numbers of cities, villages and rural communities which are now seeking permanent school and community nurses as a result of the brief experience in this service which the epidemic brought about.

THE COST OF PREVENTABLE DISEASES IN ILLINOIS.

The State Department of Public Health has just completed a study of the mortality and morbidity from communicable diseases in Illinois, the results of which, expressed in terms of dollars and cents, are convincing if not appalling. The diseases included in this study are typhoid fever, malaria, smallpox, measles, scarlet fever, whooping cough, diphtheria, epidemic meningitis, poliomyelitis, tuberculosis and pneumonia. In computing the costs of these diseases, the life of an adult was estimated at \$3,000.00, and of a child, \$500.00, while the cost of the funeral of an adult was placed at \$100.00 and of a child at \$50.00. For the medical and general care, allowances were made as follows: Typhoid fever, \$75.00; malaria, \$10.00; smallpox, \$25.00; measles, \$10.00; scarlet fever, \$25.00; whooping cough, \$10.00; diphtheria, \$25.00; epidemic meningitis, \$25.00; poliomyelitis, \$50.00; tuberculosis, \$600.00, and pneumonia, \$75.00.

No allowance was made for the cost of time lost due to illness of children; but the following allowances were made for adults: Typhoid fever, \$125.00; malaria, \$150.00; smallpox, \$75.00; epidemic meningitis, \$35.00; tuberculosis, \$1,400.00, and pneumonia, \$60.00.

Utilizing these figures as the basis for computation, it was found that the total annual cost of preventable diseases to the people of Illinois approximated the staggering sum of \$154,881,685.00. This represents an average cost of \$24.67 to each man, woman and child in the State.

The total assessed valuation for purposes of taxation in Illinois is \$2,577,990,810.00. The annual loss

from preventable diseases averages 6.01 per cent of the assessed valuation in the 102 counties of the State. In some counties this average runs exceedingly high. In Hardin County the loss is 29.71 per cent of the assessed valuation, while in Kendall County the per capita loss amounts to \$124.16.

In order of their annual cost to the State through morbidity and mortality, the several diseases rank as follows: Tuberculosis, \$114,905,500.00; pneumonia, \$30,909,360.00; typhoid fever, \$3,006,900.00; malaria, \$2,660,860.00; diphtheria, \$1,156,625.00; whooping cough, \$735,220.00; smallpox, \$675,600.00; poliomyelitis, \$461,600.00; measles, \$456,020.00; epidemic meningitis, \$425,700.00; scarlet fever, \$388,300.00.

It is interesting to note that a tax of one-fourth of a mill assessed in Illinois for public health purposes would afford a sum of \$644,490.00, which would make possible the creation of machinery which would materially decrease these diseases in the State and would pay enormous dividends to the people.

TYPHOID FEVER AT MOLINE

A third outbreak of typhoid fever within a period of a year at Moline, Rock Island County, has caused a thorough investigation by the Division of Communicable Diseases and the Division of Sanitation of the State Department of Public Health, with the result that the disease has been traced to the milk supply of one Rock Island County dairy. During this last outbreak of the disease there were 58 cases reported.

It will be recalled that up to March, 1918, there had been something over 100 cases of typhoid fever in Moline. At that time suspicion pointed strongly to the municipal water supply. With a fresh outbreak in June, there were about 135 cases and, at that time, investigation confirmed the suspicion that had rested on the city water. It was ascertained, in fact, that raw and untreated water from the Mississippi River had gained access to the regular city supply which had otherwise been safe for use.

The present epidemic, due to the milk supply, illustrates a danger which always exists where typhoid fever has prevailed and which exists after the original source of infection has been removed. The milk supply is thereafter in greater danger of being contaminated by a typhoid carrier. It also points out the absolute necessity of pasteurization of the milk supply in any community where there have been cases of typhoid fever together with the inspection of dairies and the careful observance of all dairy employes or other food handlers.

EXAMINATION OF WATER FOR COMMON CARRIERS.

Through an arrangement with the United States Public Health Service, the Division of Sanitation of the State Department of Public Health has undertaken the examination of water supplies used by all common carriers in Illinois. For this purpose specimens are collected at the source of supply by local health officers and transmitted to the laboratories at Spring-

field. After examination, the Department of Public Health certifies its findings to the United States Public Health Service, which organization deals with the several railway companies.

Through this arrangement it is expected that better and safer water supplies will be furnished to all transportation companies in the State.

HOUSING CONSTRUCTION AT ROCK ISLAND.

Through investigations by the Division of Sanitation of the State Department of Public Health and conferences with the United States Housing Corporation, the buildings that were being constructed by the Government at Rock Island have been so remodeled that the details of house plumbing are now in exact accordance with the Rock Island city ordinances. The first building constructed by the Government Housing Corporation provided for drains and other plumbing fixtures of a type not approved by the Municipal Ordinances. An appeal was made to the State Department of Public Health. Upon the completion of a thorough investigation and a report, submitted by the Division of Sanitation, the Housing Corporation modified its plans to the entire satisfaction of the local authorities.

NEW PUBLIC HEALTH CIRCULARS.

In addition to the rules and regulations for the control of influenza and pneumonia and the circulars of information on these diseases, the State Department of Public Health has issued rules and regulations for the control of typhoid fever and typhoid carriers and has in press a sixteen-page circular on the Cause, Prevention and Treatment of Pulmonary Tuberculosis. These rules and circulars will be sent without charge to health officers, physicians or other interested persons.

A BILL FOR FULL TIME HEALTH OFFICERS.

The State Department of Public Health is making a study of the laws of other states relative to full time county or district health officers and is conducting an investigation of the degree of success with which these laws are operated, for the purpose of preparing a bill for full time county health officers in Illinois to be introduced in the forthcoming General Assembly.

The so-called sanitary health district law empowers two or more adjacent municipalities, townships, or road districts to combine and levy a tax for the employment of the full time district health officer to be recommended for employment by the State Department of Public Health after competitive examination, and for the establishment and maintenance of complete public health machinery. This law, however, is entirely optional. It is hoped that a new law may be secured which will render the employment of county health officers mandatory or which may be so written as to encourage the employment of such officers by a large number of the counties of the State.

ILLINOIS "INFLUENZA POLICY"

In view of the marked difference of opinion in regard to the best methods for the prevention and control of influenza and the wide publicity which has been given to this difference of opinion within the past few weeks, the State Department of Public Health has issued a bulletin outlining its policy in connection with the disease and generally reaffirming the rules and regulations and suggestions promulgated during the earlier part of the epidemic.

The Department lays special emphasis upon the necessity for the isolation of victims of the disease or those who are suspected to be suffering from the disease, maintaining that this personal isolation, if carried out thoroughly, is more effective than any other restrictive measures. The Department also insists upon the importance of prompt reporting of the cases on the part of physicians, the control of contacts during a reasonable period of incubation, the intelligent use of face masks by those persons who are necessarily brought in contact with the sick and the general observance of those preventive measures which have proven effective in the past in dealing with other communicable diseases, the exact bacterial cause of which has not been fully understood.

In recognizing the desirability of keeping schools open during the ordinary prevalence of the disease, the Department urges the maintenance of efficient medical inspection and the regular employment of school nurses.

After reviewing the preventive measures employed throughout the country, together with the conclusion of the special committee of the American Public Health Association, the State Health Department sees no occasion for changes in the rules and regulations promulgated during the months of October and November and which have been published in these pages.

DIVISION OF VITAL STATISTICS.

On account of the congested condition in the Capitol Building at Springfield, the Division of Vital Statistics of the State Department of Public Health has been compelled to occupy legislative committee rooms during the period between sessions of the General Assembly. The forthcoming session rendered it necessary for these committee rooms to be vacated and the Division of Vital Statistics is now established in permanent quarters in the State Arsenal across the street from the State House. The new quarters afford ample room for the material expansion of the Division contemplated during the next few years.

The fact that Illinois is now recognized by the United States Bureau of the Census as a registration state for deaths, has caused the mortuary figures of the State to assume statistical value which did not obtain in the past and on this account the Division is having many more demands upon it for mortuary data from both governmental and extra-governmental agencies.

NEW POLIOMYELITIS CLINIC.

The Division of Child Hygiene and Public Health Nursing of the State Department of Public Health has established an additional clinic for crippled children and victims of poliomyelitis at the Lake View Hospital at Danville. The following clinics for crippled children are now maintained by the Department: Blue Island, Moline, Rock Island, Oak Park, Casey, Ottawa, Alton, Danville, Springfield, Quincy, Chicago Heights, Evanston, Joliet and Galesburg. A number of these clinics have been temporarily suspended on account of the influenza epidemic.

SMALLPOX IN ILLINOIS.

During the past few weeks a decided increase has been noted in the cases of smallpox reported throughout Illinois. The disease has been particularly prevalent in the central and southern part of the State, but 50 cases have been reported in and about the city of Elgin. A considerable number of cases are also reported at Peoria, at Hillsboro and in certain sections of Madison County. Smaller numbers of cases are reported from Ogle, Bureau, LaSalle, Knox, Fulton, Tazewell, Logan, DeWitt, Champaign, Morgan, Christian, Shelby, Cumberland, Wayne and Perry Counties. In most instances the disease is exceedingly mild in character.

THE CONTROL OF VENEREAL DISEASES IN ILLINOIS.

No organized and rational attempt had ever been made to control venereal diseases in the United States until the necessity for such action, incidental to the war, prompted the War Department to insist that action be taken to check the spread of these diseases. Illinois was the second state in the Union to attempt regulatory measures, but other states have followed in rapid succession until now practically all of them have undertaken this work.

It was recognized by both the federal and state governments that concealed disease cannot be successfully attacked and, in undertaking the work against venereal diseases, the first step was to make such diseases reportable. Inasmuch as it was not the desire or purpose of governmental agencies to give publicity to human faults and frailties, reporting by case or key number was permitted. Shortage of funds at first limited this work in Illinois to the zones about military cantonments.

Recognizing the tremendous importance of this work, the Forty-fifth Congress enacted the Chamberlain-Kahn Bill appropriating two million dollars for the use of the various states and all but seven states have accepted this federal aid. The government plan includes educational and repressive measures as well as the treatment of the diseased. The campaign of education is necessary to bring about public interest in prevention and also to impress upon the people the necessity of securing proper medical treatment.

Compulsory reporting in Illinois disclosing the fact that less than 40 per cent. of persons suffering from venereal diseases were receiving competent medical care and that more than 60 per cent of cases were

being treated by druggists, drug clerks and advertising charlatans, or were receiving self treatment with advertised nostrums or prescriptions passed about from one victim to another. Inquiry among a large number of diseased prisoners led to the belief that the reason for this unfortunate condition is that reputable medical men are usually unwilling to treat this class of disease. In many communities even those who were able to pay liberal fees were unable to secure satisfactory treatment. In one city of 30,000 population, no physician was found who was willing to admit that he cared to treat venereal disease patients.

In view of this disinclination on the part of the general practitioner to treat venereal diseases and the inability of a very large percentage of patients to pay any fees, the only solution of the problem, as seen by both federal and state governments, is the establishment of free dispensaries or public clinics. It was recognized by the governmental agencies that strict privacy cannot be maintained in a public dispensary and consequently that those patients able to pay for private care would not be inclined to seek dispensary treatment. It is not the purpose of either the federal or state governments that these dispensaries shall render service to those who are able to obtain satisfactory care elsewhere.

As a part of the plan now operated in Illinois, the government will distribute arsphenamine through the clinics for persons unable to otherwise obtain it and, in communities where no free dispensary is available, the drug will be supplied on the request of both the patient and the physician, in which case the physician is permitted to charge a reasonable fee for the administration of the drug.

The educational work of the State Department of Health along this line includes the distribution of pamphlets and booklets, the use of illustrated lectures and motion pictures, exhibits, all of which are designed to enlighten the public to the necessity for securing prompt and proper medical treatment and to discourage the use of medical nostrums and other unscientific medication.

A recent letter sent by the Division of Social Hygiene to the druggists of the state urges that in justice to the afflicted and to those who may be innocently infected, pharmacists shall discontinue the sale of nostrums for the cure of venereal diseases and shall urge proper medical treatment. The Division urges that, whether this be done or not, druggists report all cases or suspected cases coming to their attention to local health authorities. It is stated that this letter is bringing forth unusual response and that the druggists' "honor roll" is rapidly growing.

Society Proceedings

ADAMS COUNTY ANNUAL MEETING

The annual meeting of the Adams County Medical Society was held Monday, December 9, 1918, at Elks' Club Rooms, Quincy.

Minutes of October regular and November special meeting read and approved.

In response to a request from Dr. C. St. Clair Drake for "Collaborating Health Officers," the following were appointed to act in that capacity: Drs. Montgomery, Irwin and Austini.

Dr. W. E. Davidson, Liberty, was admitted to membership.

Secretary read report for year 1918 and the same was ordered placed on file.

Officers for year 1919 were elected as follows: President, Dr. A. M. Austin, Mendon; first vice-president, Dr. H. P. Beirne, Quincy; second vice-president, Dr. E. L. Caddick; secretary, Dr. Elizabeth B. Ball; treasurer, Dr. J. H. Blomer; censors, Drs. D. M. Knapp, Mendon; E. L. Caddick and C. E. Ericson, Quincy; defense committee; Dr. John A. Koch; delegate (two years), Dr. J. H. Rice; alternate delegate (two years), Dr. E. B. Montgomery; trustees, Drs. W. H. Baker, A. W. Werner, Quincy, and J. H. Pittman, Camp Point; program and scientific program, Drs. Ball, Shawgo and Montgomery; public health and legislation, Drs. Koch, Nickerson and Beirne; social and entertainment, Drs. Beirne, Rice and Caddick.

ELIZABETH B. BALL,
Secretary.

COOK COUNTY

CHICAGO MEDICAL SOCIETY

Regular Meeting, December 11, 1918

Joint meeting American Public Health Association and the Chicago Medical Society.

1. Mental Hygiene—C. M. Hincks, Secy. Canadian National Com. for Mental Hygiene, Toronto, Ont.
2. Narcotic Drug Addiction—Ernest S. Bishop, Clinical Prof. of Medicine, New York Polytechnic Medical School.
3. Outdoor Treatment of Influenza and Pneumonia—E. R. Kelly, Health Commissioner, State of Massachusetts, Boston, Mass.
4. Serum Treatment of Influenza and Pneumonia—Lt. S. W. Hartman, U. S. N.
Discussion—S. Pietrowicz,
A. A. Goldsmith,
H. N. Bundeson.

Joint Meeting Chicago Ophthalmological and Chicago Medical Societies, December 18, 1918

1. Ophthalmia Neonatorum—Frank Allport.
Discussion—Richard Tivnen,
E. E. Lackner,
N. C. Nelson,
Robt. Black.
2. Trachoma—Clarence Loeb.
Discussion—H. W. Woodruff.

CHICAGO OPHTHALMOLOGICAL SOCIETY

A regular meeting was held February 18, 1918, with the president, Dr. Heman H. Brown, in the Chair.

SOME REMARKS CONCERNING THE SMITH-INDIAN INTRACAPSULAR OPERATION FOR CATARACT.

DR. FRANK ALLPORT read a paper on this subject, in which he stated that the most important phase of the cataract subject before ophthalmologists at the present time is what is popularly known as the Smith-Indian operation, as performed by Major Smith and modified by many surgeons of less experience. This procedure consists in the removal of the lens in its capsule after the method proposed by Major Smith and, when successful, produces brilliant and ideal results.

The only question for American ophthalmologists to decide is, whether this operation is the best one to perform. He would not attempt to speak for others, but personally he does not feel justified in adopting this operation in his own practice. If he could get the average percentage of good results by safer methods for his patients, who come to him for vision, and not for experimental surgery, it is his duty to give them the best that is in him, and he was sure this would not be the case if he began doing the Smith operation. He is perfectly willing to acknowledge that Major Smith and a few other East Indian operators of enormous experience, who do many of these operations daily, can do them successfully and achieve a large majority of brilliant results. He concedes this, although he contends that statistical results of all these operations might not be as convincing as the intracapsular operators desire. These poor blind people make cataract pilgrimages to the Smith shrine, are operated, and then return as quickly as possible to their distant native hills and are never seen or heard from again, thus rendering the collection of accurate ultimate statistics impossible. For this reason, we may never know what all the end results are of this much extolled surgical procedure. Smith's patients in India were tractable, patient, obedient people, unpoisoned by stimulants and excessive and rich food. Quick healing and slight reaction should be the rule under these circumstances. Should Smith, however, come to America, he would be confronted by an entirely different class of patients. He would operate on a large number of unmanageable, impatient, nervous, disobedient, opinionated people, accustomed to servility from others, whose bodies have grown fat, flabby and diseased by laziness, gluttony, drink, auto-intoxication, syphilis, and so on, and with whom slow healing and considerable reaction might be reasonably expected. If this is true, then those operators of less experience than Smith will surely get even poorer results than he would. On ac-

count of his natural skill and immense and unprecedented experience, Smith has acquired a skill and dexterity unequalled by any living man. He could do things no one else could do; he could meet emergencies better than any cataract operator in the world.

The greatest good to the greatest number should be the motto of all cataract operators, and the speaker is sure that this result cannot be attained in this country by using the Smith-Indian operation. Some intracapsular operation may be, and he believes will be devised, that will be suitable for average operators, but the Smith-Indian operation is not the one. Some claim that this operation is not so difficult after all, but the speaker is confident that only a few overzealous disciples entertain such optimistic views. The fact is, it is a complicated, difficult and dangerous surgical procedure, except in the hands of a few men like Smith and other East Indian surgeons, and even their hands might lose their cunning unless they were kept in constant practice.

The author believes that men in this country, who only operate a few cases a year, should not unnecessarily risk vision and the happiness of those patients who confide themselves to their care, because they, for one reason or another, are determined to risk the Smith-Indian procedure. The speaker thinks, therefore, rather than attempt this brilliant procedure, which he believes should only be used under favorable circumstances by exceptionally expert and experienced surgeons, that we might be better occupied in perfecting the quite satisfactory operation with which we are already familiar, and in reaching out along more conservative lines for the future intracapsular operation.

DISCUSSION

DR. WILLIS O. NANCE expressed the belief that the Smith-Indian operation would never become the popular operation for cataract. The operation requires a special training and a special technic, that comparatively few ophthalmologists can ever attain. It has always seemed to him to be a much more difficult operation than the old Von Graefe procedure. The speaker felt that pressure exerted on the eyeball, as is necessary in the Indian operation, was an element that should be avoided as much as possible in the ideal cataract operation. The Smith incision is not safe, as in the old operation, in which the incision is carried beyond the limbus with a conjunctival flap. He could not see how the incision, made well in the cornea, could help but be responsible for the creation of astigmatism, although he has seen some published reports to the effect that astigmatism is no greater in the new operation than in the old. The incision, in his opinion, must necessarily be more liable to infection than the limbus incision.

The dressing advised by Smith has never met with Dr. Nance's approval. He has never been able to bring himself to the belief that the bandaging of the eye, upon which an operation has been done, should be left ten days without an inspection of the eye.

The technic of the Smith operation is a more or less delicate one, and must be learned carefully and practiced many times, if good results are to be obtained.

There is, of course, an advantage in operating in some cases of immature cataract, but the speaker, personally, would prefer to wait until the lens had become opaque.

Dr. Nance prefers to adhere to the capsulotomy operation rather than to adopt the Smith-Indian procedure. If he had the opportunity to do one hundred or more of these operations, at the hands of Smith, he might feel entirely different about it, but few surgeons receive that training, and until we do precaution and safety would naturally indicate the employment of the older method.

DR. G. HENRY MUNDT stated that he understood the essayist to say that in satisfactory cases the intracapsular cataract operation was probably better than the old capsulotomy operation. This the speaker granted. Dr. Allport, however, has placed the proposition in a way to show that the intracapsular cataract operation could not be done satisfactorily by the average operator, with which he did not agree.

Referring to the average operator, the speaker saw no reason why the average operator, unless he was thoroughly satisfied with the operative procedure that he was doing, could not develop intracapsular cataract technic as well as he could develop capsulotomy technic.

As to the amount of pressure necessary to produce collapse of the globe, if the operation was done properly sufficient pressure would not be exerted to produce collapse of the globe. If the lids were properly held, he did not believe the proportion of extruded vitreous would be as great with the intracapsular cataract operation as it would be with the old capsulotomy. If a man once mastered the technic of the intracapsular cataract operation he would be satisfied with it.

As to the proportion of astigmatism in the corneal incision, he did not believe it was any greater from the intracapsular cataract operation than it was from capsulotomy.

With reference to the length of time to leave the bandage on, this was a detail which he believed was a good one. The trend of surgery today was to leave bandages on longer than was done a few years ago.

Finally, the intracapsular cataract operation was no more experimental surgery to the average operator than was the capsulotomy operation.

DR. H. W. WOODRUFF showed a case in which a cataract operation had been performed in both eyes. In itself there was nothing especially remarkable; but in connection with Dr. Allport's paper it served to demonstrate an important point. One eye was operated on for cataract by simple extraction five weeks ago, and the other eye had the intracapsular operation performed on it three weeks ago. The visual results were the same in each eye at this time—20/30 with lens correction. The reason the intracapsular operation was performed on the second eye was because the lens was hypermature; the capsule refused to be cut, and the lens came out in the capsule. Iridectomy was done because the lens would not readily come through the pupil without that operation. In other words, it was an operation of necessity, while the first one was an operation of choice. The point to be emphasized is that there is no single method which should always be performed in every case of cataract.

He believes that the intracapsular operation may be one of necessity, while the simple extracapsular operation should be in selected cases the one of choice. He thought ophthalmologists made a mistake in attempting to prove that one method is the proper method in all cases of cataract. He believed that ophthalmologists had learned a great deal from the exploitation of the Smith operation. There had been times when he thought he should do that operation, but as he was so much more familiar with the ordinary operation he had confined himself very largely to it, and furthermore, it was so difficult to change one's technic that he had so far, excepting in very few cases, not gone over to this operation. In a person of middle life, say fifty years of age, in a physician, who was unfortunate enough to develop cataracts, one of them mature and the other one still immature, so that he was still able to attend to his routine work and was in perfect physical condition except for these cataracts, he would consider it a shame to cut out a piece of that man's iris, unless it was absolutely necessary. The visual results might be perfect (20/20) following the intracapsular operation, but when such a person went out into the sunlight he would have difficulty in recognizing objects quickly. He would not have the quick, acute vision that the man would who had a perfectly good pupil. He had noticed this about cataract

patients, that while their vision may be 20/20 when tested, still it took them some time to quickly recognize objects. When one operated on a brother medical man in active practice he felt that that man was entitled to absolutely the best that one could possibly give him, and personally he knew he would appreciate very much retaining the sphincter muscle of the iris. So unless it was absolutely necessary, he would not do such an operation on such an eye which would involve the cutting on the iris. However, if he knew that the lens was hypermature, then the intracapsular operation was the better operation because there could be difficulty in removing the lens from the capsule.

Something had been said in the discussion about the use of retractors in holding the lids. This was one thing about the Smith operation that the speaker did not like. He would admit it was probably only a personal objection on his part and perhaps of no great value, nevertheless, it had always seemed to him as if the assistant holding the lids was in the way, and when he got ready to operate he felt like brushing them all aside and getting at the eye alone. He felt that he did not want anyone else to touch the eye or to touch the lid. He felt absolutely safe in the average case if he had good anesthesia. It was so long since he had seen the loss of vitreous in an otherwise normal eye by the patient squeezing his lids that he did not feel at all afraid of that, if he knew his anesthetic was working properly. He had gotten so that in many cases he used a 10 per cent solution of cocaine, and in the case he had shown tonight there was absolutely no movement of the patient in either operation. The capsule was still present in the left eye, but it was only capsule. There was no lens substance in there, so that nothing was to be feared from the needling operation. This was the only reason why the Smith operation was ever done, namely, to do away with the capsule as well as the lens. The needling was not serious at all unless one had a great deal of cortical substance and one only had that in the immature cataracts. That was another time when the Smith operation or the intracapsular operation was worth while considering.

DR. CLARENCE LOEB stated that in conversation with one of the foremost advocates of the Smith operation he had been told that one great advantage of this operation over the old style operation was in being able to get a clear pupil. Although he had operated on over 200 cases of cataract by the old method, he did not feel justified in saying that this method would always produce a clear pupil. However, he, himself, had had less than 2 per cent of secondary cataract. By making an incision well below the pupillary margin, and away to one side, drawing it all the way across parallel to the inferior margin of the lens, and bringing it back across the face of the cataract, attempting to joint the two incisions if possible, subsequently keeping the pupil dilated with atropin, at the end of four to six weeks the capsule was almost invariably retracted upward and filled out the coloboma, and by so doing he was enabled to get a clear pupil without the Smith operation. He had done the Smith operation in four cases and did so without ever having seen a cataract operation of that character done by the man who has been performing it, but simply from what he had read about it. In the first two operations the result was perfect. The result of the second operation was very good, and the third operation resulted in the loss of the eye from a low grade irido-cyclitis. The lower margin of the pupil was always drawn well up beyond the center of the cornea, so that the process of light entering the eye was undoubtedly interfered with. For that reason he went back to the old method of Von Graefe for the extraction of the cataract. He did not believe that the Smith operation was any more difficult than was the Von Graefe.

Following his first operation, the next day he noticed the surroundings of the eye of the patient, so far as he could tell beyond the limits of the bandage, were swollen, and in taking off the bandage to see the condition of the eye he found enormous swelling; both the lids were so swollen that it was impossible for the patient to open the eye. He had to open it by means of a retractor. He expected nothing else than a beginning or far advanced panophthalmitis, but to his surprise, beyond a fair degree of injection of the ocular conjunctiva, there was nothing to be seen. This edema in the course of three or four days disappeared entirely.

He would like to know if any member ever had such an intense edema following a cataract operation without any cause for it.

DR. OLIVER TYDINGS stated that if the remarks on this subject were confined alone to the Smith operation, he would not have any dispute with the essayist or the gentlemen who have discussed the paper. But if the technic could be extended, as it had been developed at the Chicago Eye, Ear, Nose and Throat College, he would say that it was infinitely safer and it was possible to do the old operation with that technic. Before the introduction of the Smith operation he had long since eliminated the speculum, regarding it as a dangerous weapon. He contended that the technic of the Smith operation was the easiest and safest and best, and if a man was going to continue to do the old operation he should learn it if only for the purpose of using it when he got into trouble. With a lid retractor the operator was safe. However, one could take a nurse and train her to retract lids. The services of an expert for this purpose were not required. If one once mastered the Smith technic, he would never abandon it.

DR. WILLIAM A. FISHER said he was glad to know that the Smith operation was being discussed. The essayist and some of the men who had discussed the paper acknowledged that they had not had enough experience in the intracapsular operation to speak with authority. The speaker did not think that anyone should undertake to remove a lense in capsule if he did not understand the technic. One could get experience in the Smith technic without going to India, because it was not so much experience that one should have in a cataract operation as it was that he should have experience in the complications that often occur during a cataract operation by any method.

The speaker exhibited an eye of a six weeks' old kitten in which the cornea was eleven millimeters in diameter, stating that the cornea was thin, like the human, and one, if ambitious, could get these eyes by the hundred. If the operator believed it would take a hundred operations to understand and master the technic, he could get that number, or two hundred, if necessary. He could practice the spoon and needle delivery, which should be mastered before the operation was attempted at all. Tension in this eye was the same as in the human eye.

He thought that if Col. Smith was present he would have felt flattered at the wonderful opinion the essayist expressed of his operation, and that he believed Smith was the only man that could do it right, but 90 per cent of the lenses extracted in northern India are extracted in the capsule and they were not extracted by oculists who occupied chairs in a university, but by general surgeons whom Smith had taught. He did not believe Col. Smith would expect everybody to agree with him, and the speaker said he certainly would not expect everybody to agree with him, but he believed that there would be a different feeling regarding the Smith operation if the men would pay more attention to the technic and less to criticism of it.

The essayist stated that it was his opinion that operators in the U. S. A. who were removing lenses in capsule would not care to have their results published, but he surely knows that there are reliable intracapsular statistics which could be readily obtained, with a comparison of other methods.

The speaker then presented the following intracapsular statistics regarding vitreous loss.

	No. of operations	Vitreous loss
Smith, 1904	2,616	6.76%
A. Knapp, 1908.....	104	11.5%
Vail, 1912	358	2.2%
Clark, 1912	245	4.0%
Meading, 1912	325	10.0%
Shepard, 1912	650	5.2%
Smith, 1913	150	2.0%
Fisher, 1914	576	7.0%
Total.....	5,022	6.37%

Visual Results Capsulotomy Method

	Cases		
H. Knapp	1,000	20/40 or better	52%
Duncan	100	20/40 or better	69%

Webster	100	20/40 or better	57%
Weeks	100	20/40 or better	7.8 or 54.5%

Intracapsular Results

Consecutive

Cases

A. Knapp	100	20/40 or better	70%
D. W. Greene....	203	20/40 or better	72%
A. S. Greene....	109	20/40 or better	86.2%
Fisher	94	20/40 or better	74%
Meeding	83	20/40 or better	73%

Total.....689

Vision 20/40 or better, capsulotomy method, 54%.

Vision 20/40 or better, intracapsular method, 73%.

DR. FISHER exhibited at the Chicago Ophthalmological Society, January, 1915, 12 cases. There were ten patients with average vision of 20/25; no losses. Smith in 1912 reported 132 selected cases operated by him personally with vision of 20/40 and better, 100 per cent. Gidney reported 100 patients, both eyes operated, one eye intracapsular, and the other capsulotomy. Intracapsular cases, 100 20/40 or better, 54 per cent. Capsulotomy, 100 20/40 or better, 18 per cent.

From the above statistics it would seem that ophthalmic surgeons who are operating by the intracapsular method cannot be expected to abandon it and return to the capsulotomy method just because some operators who are unfamiliar with the technic choose to condemn it.

DR. ALLPORT, in closing, stated that he firmly adhered to what he had said, in spite of the remarks of Dr. Fisher and others concerning the ease with which the Smith-Indian operation can be performed. He cannot agree with these gentlemen that it is safer than the operations usually performed in this country. He believes it to be a much more difficult and hazardous procedure than the ordinary operation, and one that should only be indulged in by those of superior surgical skill, special clinical education, and an extensive cataract practice. He would like to ask Dr. Fisher and others why they felt it necessary to travel to India for instruction if this operation is so simple. He still contends that this procedure is not adapted to the average American operator, with an average cataract practice.

ANGIOMA OF THE ORBIT

DR. GEORGE W. BOOT reported the following case: I saw this girl first about the middle of December. She is a German 21 years of age, and single. She gave no history of accident or previous illness. She first noticed trouble with her eye about eight or nine months ago, at which time it was blood-shot and somewhat swollen. This condition has gradually grown worse. As you see, she has a soft swelling at the inner part of the orbit; the upper eyelid is swollen; there are large tortuous vessels crossing it, and the trouble has distinctly increased since I saw her in December, when I felt a swelling, and noticed a thrill with it, and in listening with the stethoscope I heard a bruit over the whole face. There are no lesions inside the nose. I thought possibly this growth might extend into the nose, but the nose is normal. I had stereoscopic x-ray pictures taken, but there was no sign of erosion of the bone.

The question of diagnosis came up, and I believe this is a hemangioma. I find that hemangiomas are mentioned in practically all text-books, and ordinarily they are classified under three different forms, the capillary nevus or the so-called port wine marks, cavernous angioma, and plexi-

form angioma. Fuchs says angioma of the orbit is rare, but Axenfeld says it is not so rare. I have looked over the Index Medicus for the last five or six years and have only found five cases recorded, so that the condition probably is quite rare.

Angioma is very apt to be mixed with other forms of tumor, such as angiosarcoma, or myxo-angioma, or fibroangioma, or angiofibroma, depending upon the kind of tissue the tumor is made up of.

The symptoms as given for this condition are usually, first, exophthalmos. The patient notices that the eye is more prominent than usual. In this case exophthalmos is well developed. This condition lasts for a considerable length of time ordinarily, and then swelling is noticed outside of the eyeball. In this case it is seen alongside of the nose. This swelling is apt to be somewhat bluish in color, soft, not painful, and it can be made to disappear by pressure, but returns again when pressure is removed. Norris and Oliver say that these angiomas are not accompanied by bruit or thrill. Ball says they are usually accompanied by bruit or thrill. This case is accompanied by bruit.

Roemer mentions varicose veins of the orbit, but the cause of the varicose veins is not given.

The capillary form of angioma is congenital, or it appears shortly after birth. The cavernous form and plexiform form of the trouble develop later in life. Varicose veins develop still later. In some forms the angiomas are encapsulated.

As to the treatment advocated, when the growth is encapsulated, excision by means of the knife is perhaps the best method. Most authors apparently would recommend electrolysis for angioma.

In the American Encyclopedia of Ophthalmology I find a report of one case in which a man used absolute alcohol for angioma through the conjunctival surface of the lid. He injected three drops, then later six drops, and repeated six drops on two other occasions, with the result that the angioma completely disappeared. In this patient I had contemplated the use of electrolysis, but the growth has increased since I saw her last, and it extends out to the side of the nose and over to the other side of the face, so that I doubt whether electrolysis would be advisable in this case.

Among the dangers connected with this trouble are septic thrombophlebitis, and that is particularly apt to follow electrolysis. I would be afraid to use electrolysis in this case on account of the possibility of embolism. I am in doubt as to what should be done. Ligation of the carotid would probably help, but in the few cases I have been able to get track of where that has been done, the results have not been permanent because of the collateral circulation which is established.

If any of the members have had an experience of this sort I should like to hear it.

DISCUSSION

DR. OSCAR DODO stated that he saw this case when Dr. Boot presented it at the Evanston Branch of the Chicago Medical Society in December. There was quite a change in the appearance of the condition since that time, there being considerable extension of the swelling above the nose at the inner angle of the orbit; also enlargement of the veins at the outer margin of the orbit, but the proptosis was no more than at that time. At present the bruit was much more marked and pulsation could be felt all about the orbit, as it could not be at the time he first saw the patient.

The diagnosis in this case was rather difficult. He thought it was an angioma when he first saw the case in December. However, he questioned this diagnosis tonight for the reason of the greater distention of the veins and the distinct pulsation which was present. By pressure over the carotid the pulsation and distention of the veins was markedly lessened and one could see the recession of the eye. It looked to him as though there was a probable connection between the artery and the vein, and that this was a typical pulsating exophthalmus. In contradistinction to this we might have an angioma with distention to which the pulsation was communicated from the artery.

As to treatment, the ligation of the carotid was the first thing that should be done in this case. He did not know whether that would be sufficient to cure or not, but it would at least relieve the pressure and make it safer for further operation should such be necessary. Unless something was done, it looked as though the case would go on to disastrous results.

DR. OLIVER TYDINGS stated that while he had never seen a case of the kind described, but in connection with it he would like to relate a case that he observed many years ago. In that case one could hear a bruit across the room. There was no external appearance at all. He had the late Dr. Francis T. Miles, neurologist, and Professor of Anatomy at that time in the University of Maryland, see the case, and he put it down as a tubercular condition of the meninges that produced the bruit and cautioned him very carefully to have a post-mortem made. But the patient would not die, he could not get the post-mortem. The last time he saw the man was ten years ago and he understood he was still living and well. The case was exceedingly interesting, in that the patient got well without any trouble and without any treatment. If he were going to do anything in an operative way on the case Dr. Boot had reported, he would either use hot water or something that he had seen mentioned lately, namely, the use of quinine and urea for the purpose of producing obliteration of the aneurysmal varix.

DR. BOOT, in closing the discussion, said that he had neglected to say in his previous remarks that there were no particular changes in the fundus. The veins were somewhat engorged, but this was about all. He had considered the possibility of arteriovenous aneurysm, but the absence for any cause of such aneurysm led him to think that it could hardly be that.

CHICAGO LARYNGOLOGICAL AND OTOLOGICAL SOCIETY

The regular monthly meeting of the Chicago Laryngological and Otolological Society was held in the South Dining Room of the Palmer House on Tuesday evening, February 19, 1918, at 8 o'clock.

The President, Dr. Frank Allport, in the Chair.

SCIENTIFIC PROGRAM

DR. CHARLES L. ADAMS, Kokomo, presented a paper entitled, "Indications for Variations in Technic in Tonsillectomy."

The subject was discussed under the following subheads:

(A) The free tonsil.

(B) Tonsils with firm lymphoid connection to tongue.

(C) Tonsils with large upper lobe hidden in supratonsillar space.

(D) The submerged tonsil.

The article was prefaced with quotations from papers by men who are confident that they have developed technic applicable to all types of tonsils. This was briefly commented upon.

The body of the paper dealt with the various conditions met with in different throats and reasons why it is necessary to meet them with variations of technic in order to gain a perfect result.

The paper closed with a declaration by the writer that no one technic or instrument can be applied to all types of tonsils, because no one has devised a tonsillectomy that will meet all conditions encountered.

DISCUSSION

DR. OTTO J. STEIN congratulated the author and thought he had grasped the subject exceedingly well. He thought his classification of tonsils was accepted by all. There was one addition to the classification which the essayist had failed to recognize, but which he thought men who were doing this type of work should include. The specialist frequently saw the ill result of operations performed by fairly good operators and particularly those performed by men who were not especially well acquainted with the throat and the result was sometimes very poor. He referred to the type of case which had been operated upon and pieces of tonsil or small masses of lymphoid tissue had become buried in the scar tissue. Specialists saw such cases frequently and in some instances the tonsil had been taken out with the capsule remaining intact, and this tissue afterward took on hypertrophic growth and the patient had to be reoperated. It was sometimes difficult to tell what the patient had done. In these cases the question of the instrument to use was very important. Most of them had to be resected. He had seen several such cases, one of them being a case which was seen by Dr. Sluder when he was first demonstrating his instrument at the County Hospital. One of the cases had been operated upon and it was impossible to use the instrument for there was practically no tonsil tissue to be seen. They all tried to use the Sluder instrument and besides, attempts were made to dissect out the tissue, but it was found that the newly formed tissue around the aponeurosis contained small pus pockets and it was only by painstaking work that it was dissected out. These cases come up frequently in private practice and in the clinic and there was a question as to whether there was really any tonsil tissue present or not.

He cited the case of a patient seen that day in which the patient said she had had her adenoids taken out and was not sure whether the tonsils were taken out or not. She had a lot of trouble and he felt that there undoubtedly was lymphoid tissue buried in the scar tissue which had to be dissected out. He believed this type of case should be taken into consideration.

Dr. Joseph Beck said there had been so much tonsil discussion last year that he supposed everyone was satiated with the subject. He thanked Dr. Adams for the compliment he had paid the Beck tonsillectomy in his paper. He thought there was another type of tonsil which had not been mentioned—namely, the tonsil which had had a great many peritonsillar infections with abscesses that had been opened and drained. Those cases presented special difficulties in removal. In many of these cases and cases of the type mentioned by Dr. Stein he had been surprised to find that he could deliver them into a very small ring of the snare although he had

thought they would have to be dissected. He believed the careful dissection under local anesthesia still held first place for adults; he still like to dissect the small flat tonsils from their attachment. He was interested in the opening words quoted from Dr. Fletcher and also in the remarks frequently heard from Dr. Kenyon on preservation of the tonsil tissue and particularly the capsule. Dr. Beck had frequently spoken of the intracapsular operation—meaning by that, leaving the capsule intact, in place, and obtaining a perfect tonsillectomy, and he was prepared to demonstrate that operation to anyone who should take the trouble to see it. It meant the delivery of the tonsil with the ring instrument up to the time of twisting it off, and while the cauliflower mass of lymphoid tissue was protruding, the capsule turned upon itself. The lymphoid tissue was removed with an instrument as employed to express for traucoma bodies. In this way there was nothing left but the trabeculae and capsule. He was sure everyone operating on tonsils had been surprised upon removing a small tonsil to find a large cavity. This was not surprising to him, knowing that the constrictor muscles of the pharynx were intimately adherent through the aponeurosis to the capsule and when the capsule was removed, like the raphe of any muscle, the tissues would spread. It lost the attachment and the action of the muscle was in the opposite direction. He believed in the cases of vocalists where the voice was of high potential value one might develop the technic of intracapsular tonsillectomy, but he was not yet ready to make any final statement and certainly not willing to substitute the regular tonsillectomy with capsule intact, especially in cases of chronic tonsillar disease with systematic conditions probably due to it.

Dr. Elmer L. Kenyon called attention to the regularity of deformity following tonsillectomy and to its bearing on the voice. He also spoke of the development of the operation of tonsillectomy historically. A crude tonsillotomy had been abandoned for the radical tonsillectomy without attempting a complete intracapsular extirpation of the lymphatic tissue. Until it was shown that a thorough intracapsular operation was incapable of accomplishing all that tonsillectomy was capable of accomplishing in the matter of removing infection, tonsillectomy must rest on an insecure foundation.

Dr. Kenyon had been doing an intracapsular dissection—"intracapsular lymphoidectomy"—from time to time, with much reduced deformity, and, so far as yet observed, with thorough and even complete extirpation of the lymphatic tissue and of infection. He also spoke of the danger of permanent nasalizing of the speaking voice, if the soft palate happened to be relatively short, for tonsillectomy tended to diminish the backward reach of the soft palate.

Dr. J. Holinger said that suppurations in the nose and nasopharynx may spoil the result of the best tonsil operation, as will also chronic inflammations in the pharynx. Another reason for unsatisfactory results was the frequent individual tendency to the formation of large scars.

Dr. Charles G. Adams, in closing, thanked the Society for the honor shown him in admitting him to membership and for the discussion given the paper. He thought if there was no discussion at all a paper fell flat, and if the discussion tore the paper to pieces the author felt badly, so he thought he had fared very well.

Dr. Charles M. Robertson discussed some investigations which he was carrying on in connection with aviation tests, and illustrated his talk with charts.

CHICAGO OPHTHALMOLOGICAL SOCIETY.

A regular meeting was held March 18, with the president, Dr. Heman H. Brown, in the chair.

A CASE OF SEVERE OCULAR INJURY BY BROKEN SPECTACLE LENS.

Dr. Willis O. Nance presented the case of Eugene C., aged 30, who, while working at his trade of machinist, on December 29th, 1917, was struck on the head by a falling ladder. He was wearing rimless spec-

tacles. The right lens was broken, and he sustained a horseshoe-shaped incised wound of the conjunctiva, sclera and choroid of the corresponding eye. The wound occupied the inferior temporal aspect of the eye and extended from the limbus, approximately 8 mm. downwards and outwards. He saw the patient at St. Bernard's Hospital about midnight of the day he was injured. Vitreous and shreds of choroid were protruding from the wound, and the iris drawn down into its lips. The protruding shreds were abscised. A firm bandage was applied and patient kept in bed. He left the hospital January 14, and was under observation until February 10th, when he returned to his work. At the time of discharge, the vision in the injured eye was 20/50 minus. The wound healed splendidly and the cicatrized surface was smooth and regular.

The infrequency of such injuries is shown in the report of Hans Lauber, who states that he has only seen five cases in 150,000 eye injuries, or a proportion of but one to 30,000. His first case was seen after he had observed 85,000 cases of ocular injuries.

After referring to other cases reported in the literature, Dr. Nance quotes from a report he presented to the society 11 years ago, in which he drew the following conclusions:

1. That injuries to the eye by broken spectacle lenses are extremely rare, and that the popular prejudice against the wearing of glasses by children, on the theory that the eyes are likely to suffer injury by the lenses being broken, while worn, is founded more upon fancy than upon clinical evidence.

2. That wounds of the ocular appendages and surrounding parts by broken spectacle lenses, while not common, occur much more frequently than those involving only the eye itself.

3. That injuries of this character occur much more frequently among wearers of spectacles than nose glasses, probably for the reason that the latter being held less firmly before the eyes, are displaced by violence sufficient to break the lens.

4. That by far the greater number of injuries result from the breaking of rimless spectacles, there being no instance in the author's series of cases where injury was induced by the rimmed variety of spectacles.

5. That injuries of the kind indicated are extremely rare in patients under 14 years of age, that they occur more frequently in females than in males, and that the wearing of veils probably holding the lenses more firmly in position upon the patient's face, has a tendency to increase the danger of injury.

Personal observation and the reports in the literature since that times does not lead the author to change his views.

(b) NON-PIGMENTED INTRAOCULAR NEOPLASM IN AN ADULT.

Dr. Nance exhibited a patient, 24 years of age, whose occupation was that of camera operator, he having been employed in this line of work for several years. Eight months ago, in Los Angeles one afternoon he was playing ball and noticed that he could not see very well, that things appeared to be blurred. Up

to that time his eyesight was pretty good. Shortly after noticing this blurring of vision he returned to Chicago. His mother told him that she noticed something white in one of his pupils. Patient secured a position in Chicago in which he was required to do considerable near work, and having some headache he consulted the speaker on March 16. Up to that time no physician had examined his eyes. Patient has an intraocular growth that seems to arise from the superior temporal aspect of the eye, probably from the retina or choroid, and extends downwards and to the nasal side. Apparently it is well circumscribed, of yellowish white color, and has several well defined blood vessels extending over it. Those members who had seen gliomata would recognize at once what appears to be a growth of that nature. As was known, glioma never occurs in adults. One man's guess was as good as another as to what this growth is. Fuchs states that sarcomata of the choroid are almost always pigmented, and although non-pigmented, so-called leuko-sarcomata very rarely occurred. Whether this is a leuko-sarcoma or not he did not know. He would be inclined to give that as his best guess. The growth is well defined. It is opaque on transillumination, and vision is nil. Patient is not able to determine perception of light. The case is very interesting. In his experience of nearly 20 years, with a rather large clinical experience of 13 years at the Illinois Eye and Ear Infirmary and in other institutions, and in his private practice, he does not recall having seen a non-pigmented intraocular growth in an adult. If any member of the society has ever seen such a case, he wished he would mention it in discussing the case.

DISCUSSION

DR. FREDERICK D. VREELAND stated that the case presented by Dr. Nance reminded him of one described by Dr. Ringueberg several years ago. From that standpoint, it was interesting to know the amount of injury that could take place by laceration of the eyeball and still prompt recovery take place. In the case of Dr. Ringueberg, the injury was greater than in this case of Dr. Nance, yet it healed kindly and the man returned to work in 16 days thereafter. This is largely due to the aseptic properties of the glass and the clean-cut edges, as well as the easy approximation of the parts following the injury.

In deciding whether there still remains in the eye portions of glass, some have insisted on taking an x-ray picture, but the x-ray does not show very much if the glass is of the lead-free variety. Dr. de Schweinitz has described a case in which a piece of glass remained in the choroid for ten years without causing any apparent irritation, showing that the eye would tolerate glass to a greater degree than some other foreign bodies.

As to rimless spectacles, the speaker also observed they were worn in the majority of cases, and that nose glasses did not occupy a fixed position and were easily knocked off. In most of the injuries previously reported the patients wore minus lenses which have thin centers, contrary to the plus lenses, which have a rounded surface. It is the sharp edges in the centers of minus lenses that produce laceration. Plus glasses are more protective than minus. A large object striking an eye would produce serious injury independent of the lacerating tendency of the glass, while small objects are deflected by the presence of the lens. In a former report, contrary to what Dr. Nance had said, the speaker found that more men's eyes were injured in this particular manner than Dr. Nance had stated, and the ophthalmologists interviewed at that time were of the opinion that these eye injuries most frequently occurred

in men who were engaged in industrial pursuits. The injury, though, was often the result of a household accident, or those engaged in athletic sports. From an industrial standpoint, a large majority are protected by lenses.

Concerning the tumor case of Dr. Nance, such cases were interesting from a diagnostic standpoint. As to the origin of this growth, from its location he was rather inclined to believe it sprang from the ciliary body. Growths from the ciliary body are not observed early as a rule until they can be seen through the pupil. In one particular case he recalled, the growth was situated on the choroid farther back, and he advised consultation. A diagnosis of intraocular tumor was made. Transillumination was perfect. Needle puncture was resorted to, which indicated there was a tumor present. There was more resistance than normal. He decided to trephine and see if the detached retina would go back into place, but the patient went back to Iowa and he did not have a chance to do it. He asked for an expression of opinion in regard to trephining in such cases.

As to Dr. Nance's case, he thought it might be called a leukosarcoma. The vascularity in these cases was variable. There was some vascularity in this case, but there did not seem to be any irritation of the iris. Growths springing from the ciliary body sometimes push forward and cause iris displacement, while syphilis and tuberculosis cause early iritis, which does not obtain in this case.

DR. CLARK W. HAWLEY stated that he had removed an eye which presented a picture very similar to the case related by Dr. Nance, but the growth proved to be malignant. When the patient first came to him he had vision in certain fields. Finally, vision was lost and he told the patient that he had a growth in his eye which might or might not be malignant. The probabilities were that he would be better off without that eye than with it. He would be inclined to hesitate in deciding whether this growth in the case of Dr. Nance was malignant or not.

DR. OLIVER TYDINGS asked Dr. Hawley what was the underlying pathology in his case.

DR. HAWLEY replied that he did not remember the details any further than what he had stated. The report from the pathologist stated that it was malignant.

DR. NANCE asked Dr. Hawley whether he noticed where the tumor arose.

DR. HAWLEY replied that he thought it arose from the outer portion of the retina well forward and extended downward and inward.

DR. NANCE asked whether it was a retinal or choroidal tumor. DR. HAWLEY replied that it was entirely retinal; that he had the specimen in his office and would look the matter up and see.

DR. OLIVER TYDINGS said that the report of Dr. Hawley brought up the possibility of whether this might not be a form of retinitis proliferans with a tubercular base. The fact that it was non-pigmented would show that the growth did not arise from the choroid, but was of retinal origin.

DR. NANCE stated that he had intended to say that tuberculin was given in his case and a Wassermann test made within the last ten days, both of which were negative.

DR. TYDINGS stated that instead of making a Von Pirquet test, he would start the patient with two milligrams of tuberculin and see if he could not get a reaction. If he did not get a reaction he would give the patient three milligrams, and follow that with four, perhaps the next time with six, to see if he could not get a reaction.

With regard to trephining in cases of sarcoma, he did not know of any one who would advocate cutting into a sarcomatous growth. If there was a possibility of making a diagnosis ordinarily of melanosis, the history would clear up that, and that would be in a case of trauma where one would have hemorrhage from the subretinal vessels. There one would get a tumor that looked like sarcoma. If one took the history of the case he could generally elicit trauma and following on that, within a few months, one would have a blood clot settling down in the lower part of the globe, with detachment of the retina. He would hesitate very much to trephine in a case of sarcoma.

DR. WILLIAM A. MANN reported a case that turned out not to be a tumor, but a case where he had made a diagnosis of

glioma in an adult. The patient's eye had a similar appearance as the eye in the case of Dr. Nance, but there was no red reflex. The growth or mass seemed to lie back of the lens, pushing the lens forward. The pupil was slightly dilated. The eye was removed and proved simply to be an umbrellar detachment of the retina. The retina was folded in behind the lens.

DR. MICHAEL GOLDENBURG asked Dr. Nance whether he resorted to puncture with the hypodermic needle to see if there was any fluid present.

DR. NANCE replied that he did not.

DR. GOLDENBURG stated that from a hasty examination he was able to determine that the vascularization was purely retinal. The mass was translucent.

He saw a case a number of years ago similar to this which was presented by Dr. Parker and discussed by the elder Gradle. This looked very much like an intraocular tumor, but these cases were usually accompanied by intraocular tension. Sometimes this tension was absent. Lack of vascularization was rather rare in sarcoma. That it might be a well defined detachment of the retina was possible.

As to trephining in these cases, he could not see any particular advantage of that over mere puncture with a hypodermic needle. If one should get fluid and the detached retina prolapsed, that would settle the argument. The trephine simply makes a larger opening.

The question of whether the growth was malignant or non-malignant could only be determined after its removal and sections made. If it was merely a well defined detachment of the retina, it would exclude the possibility of enucleation. Sarcoma of the retina was exceedingly rare; he had never seen one, and they saw as many intraocular tumors at the Chicago Eye and Ear Infirmary as in any part of the world. These tumors usually spring from the tissues in the region of the ciliary body or at the junction of the choroid with the disk; in other parts they are very rare. The translucency of the mass, the lack of vascularization makes one skeptical.

DR. THOMAS O. EDGAR, of Dixon, Illinois, in speaking of these injuries of the eye from glasses, said that he could recall one case in his private practice, occurring a year ago. The patient, Sister B, bumped her face against the corner of a drawer, breaking her rimless spectacles. She at once felt a foreign body sensation in her eye. She was found to have in the naso-central portion of her right cornea a 4 mm. vertical wound, penetrating deeply and obliquely to the surface. Although there soon developed a faint injection in the ciliary region the wound promptly healed and the recovery was uneventful. Her lenses were convex. This afternoon he saw a second case (Mrs. A.) with an injury of the left eye of a type similar to that existing in Dr. Nance's patient shown this evening. The woman was found by her family, eight days ago, on the floor in a convulsion. The left lens of her spectacles (which were of the ordinary gold rimmed type) was found to be shattered and her left eye bloodshot. It was thought her face had come in contact with the stove. The eye when seen for the first time this afternoon exhibited an ovate shaped pupil, having its apex adherent to the infero-temporal angle of the anterior chamber. The conjunctiva at this point formed a bulla 4 or 5 mm. in diameter, but the iris did not present through the wound and there was no positive evidence of any break in the continuity of the conjunctiva.

A marked exophthalmos in this patient rendered her eye more liable to this sort of injury. One cannot be sure in this case that the spectacles, either lens or rim, caused the injury.

A report ten days later showed recovery with corrected vision same as when tested a year previously.

DR. FRED W. BAILEY, Cedar Rapids, Iowa, recalled four cases he had seen in the last ten years. One of them was in a young girl, 8 years of age, who was wearing spectacles with rims on. The injury was caused by a boy playing and striking the glasses with a poker at school, breaking the glass and cutting both cornea and iris. The other three cases were all adult men, and all of them wore minus glasses and were myopics.

DR. CLARK W. HAWLEY stated that his experiences with injuries of the eye from broken spectacles was very small indeed. He had seen but one serious case. An insurance adjuster came

to him with a history of broken spectacles, and he removed from the cornea several small pieces of glass. No scar was left. The wound was not deep enough to leave a scar. This was the only injury of the eye he had seen in clinic work or in private practice.

DR. ALFRED N. MURRAY said that he had reported a case to the Society two years ago of extensive injury to the eye from a broken spectacle lens. It was a golf ball accident, the patient wearing a minus toric lens of about two and a half diopters. When the patient was brought to the hospital he had a corneal wound about four millimeters long with prolapse of the iris. This was excised, and about a week later, when the eye was quiet, he noticed an irregularity in front of the pupil almost at the center of the cornea, and on touching it with a probe found it was a piece of glass; it prolapsed into the flocculent lens matter which, since the injury, was present in large quantities in the anterior chamber. He extracted the glass by elevating it on the tip of a keratome, and introducing a forceps through the central corneal wound, picking it out from the flocculent lens matter. The cataract gradually became absorbed and left the anterior capsule attached to the posterior surface of the cornea. He incised this attachment with a knife needle and at the same time did a discision of the posterior capsule. At the end of a year the patient had 20/24 vision with the injured eye, which was certainly a good outcome considering the nature of the injury. Patient still had the strabismus which he mentioned at the time he reported the case. There still remained, after three years, a small spicula of glass at the site of the original corneal wound where the iris prolapse had occurred. This appeared to be more or less encapsulated, the eye was perfectly pale, and the patient had had no further trouble with it. He saw no reason for interfering with it.

He reported this case to show what an extensive injury can occur without losing the eye. It also showed what could be done in the way of conserving vision under such circumstances.

DR. ROBERT VON DER HEYDT related some of the experiences he had had in relation to cases of intraocular tumor. Eleven years ago he refracted a girl whose vision was normal in each eye. Nine years ago he refracted her and could not raise vision beyond 20/100 in one eye. On investigation he found melano-sarcoma in the roof of the eye. This diagnosis was verified by Dr. Phillips and by Dr. Montgomery. Two weeks later he enucleated the eye.

Within the last two years he saw a case of detachment of the retina where there was a pigmented proliferation in the detached zone, there was reapplication and redetachment, and he had seen it go through three or four of such changes in the pigmented zone.

Within the last month he saw an interesting case of spontaneous detachment of the retina, with sudden, unexpected reapplication and absolute disappearance of the detachment, and again last week a redetachment. He was inclined to think in connection with Dr. Nance's case, in view of the possibility of sarcoma, its danger to life and because of the blindness, enucleation should be advised.

As to the value of the Wassermann test in this case, a positive Wassermann can be due to a malignant growth. In a non-syphilitic, he has recently seen such a reaction due to a very small carcinoma on the tip of the tongue.

RETROBULBAR NEURITIS DUE TO SYPHILIS

Dr. Thomas Faith reported the case of a man, Mr. C. J. J., aged 45, painter and paper hanger, first seen on Jan. 21st, 1918. Patient complained of losing vision for two or three months. R. V. = 6/200, L. V. = F. at 3 ft. General health good, except previous to 10 years ago when he suffered from rheumatism for a period of 2 or 3 years. Patient denies lues but has a distinct adenopathy and scar on penis; has been exposed to fumes of wood alcohol a number of times but never made sick or prostrated. For the past 5 or 6 years has been working as boss in gang of paper hangers. There is no family history of blindness. Both optic nerves have the appearance of a postneuritis atrophy,

i. e., they are pale but not excavated. Patient complains of no pain but a feeling of soreness when he moves the eyes about, in extreme excursions. Has a well-marked central scotoma for red and green in right eye and sees white, yellow and blue in the central part of the field, but form field is contracted. In the left eye, sees only yellow, blue and white over a very limited area to nasal side of the central fixation point. He can occasionally distinguish red with a 15 mm. square in the lower nasal quadrant about 15° or 20° from the fixation point. No symptoms of tabes or lead poisoning. Patient not a smoker, and only a very moderate drinker. Urine analysis negative. On January 4th, first fields were taken and condition above stated was found and charted. Patient was put upon calomel $\frac{1}{4}$ gr. doses for a few days. This was followed by a saline, and later Turkish baths on Jan. 29th. After two Turkish baths R. V. = 20/160, L. V. = F. at 6 ft. K. I. then ordered. Begun with gr. x and increasing to gr. xxx tid. Patient seen again Feb. 4th. R. V. = 12/20, L. V. = F. at 5 ft.; sent to Michael Reese Hospital. On Feb. 6th complete nervous examination by Dr. Sidney Kuh, who reported nervous system negative. Wassermann made at this time showed blood ++; spinal fluid ++++; blood count normal; at this time R. V. = 7/200, L. V. F. at 3 ft. Patient put on inunctions of Z. T. ofung. hydrarg, per diem; also saturated solution of KI. beginning with drops xv and increasing 3 drops each day. This was continued for six days, when 6 gm. nov. arsenobenzol was given intravenously. Vision seems slightly improving. On Feb. 17th, R. V. = 13/200, L. V. F. = at 6 ft.

We were all more or less familiar with the typical toxic amblyopias, the chief symptoms of which were reduction of vision, with relative central scotoma, with or without ophthalmoscopic changes, the ophthalmoscopic changes when present usually only amounting to blurring of the disk margins and pallor of a sector of the temporal side of the nerve head when the case was more or less recent which might give the entire disk an atrophic appearance if the case was an old one.

Authorities state that hereditary optic atrophy may occur either with or without central scotoma; that multiple sclerosis frequently has as one of its symptoms a retrobulbar neuritis, and that atrophy with or without central scotoma may be one of the very earliest symptoms of tabes or general paresis, sometimes antedating all other symptoms by many years.

Nonne records the existence of retrobulbar neuritis in syphilis and calls attention to the fact that the disease does not necessarily run a uniform course in both eyes. Alexander states that these cases are usually cases of perineuritis affecting the periphery of the optic nerve and thereby causing the central disturbance, since the peripheral fibers go to the macular region. As we all know, real cases of retrobulbar neuritis, if unrelieved, degenerate into atrophy, and Nonne among others believes that cases of isolated optic atrophy of luetic origin do occur which never

do develop into tabes, general paresis or multiple sclerosis, but this can always be questioned. The question that naturally occurs to one in the presence of such a case is: Is this case one of retrobulbar neuritis resulting from the toxemia of lues or is the optic nerve lesion but the forerunner of one of the grave diseases of the central nervous system which occurs in syphilis?

DISCUSSION

DR. E. R. CROSSLEY stated that a retrobulbar neuritis, with a few exceptions of direct infection, may be said to result from an acute or chronic absorption of toxins generated either within the body or coming from without.

DR. CROSSLEY stated that sudden changes in vision characterize acute attacks. These attacks may take place within a few days to the extent that all perception of light is absent. A dull pain in the orbital region is a characteristic symptom, and pressure on the eye-ball or any movement of the eye on part of the patient tends to aggravate the symptom. Acute attacks are more commonly unilateral and may come from direct attacks of infection, as in the orbital infections, possibly from some of the acute infectious diseases.

The vision fails gradually in the chronic form of retrobulbar neuritis and varies from a slight disturbance to an entire loss of central acuity, according to the scotoma. As a rule, there is more disturbance for color than for form, therefore the characteristic scotoma for red and green. In later stages of the disease the scotoma, which was at first relative, becomes absolute and increases, involving the peripheral field. In the central scotoma the red and green colors are the first to disappear. In most cases the central portion of the field is affected or that part supplied by the papillo-macular bundle of nerve fibers, although in an occasional case complete blindness may develop. A retrobulbar neuritis is an early symptom of disseminated sclerosis.

The treatment of these cases is the treatment of the disease causing the neuritis, and the withdrawal and elimination of the toxin producing it.

DR. WILLIS O. NANCE stated that every ophthalmologist came in contact with cases of retrobulbar neuritis of obscure origin. Dr. Crossley had mentioned some 20 diseases that might be responsible for retrobulbar neuritis. The speaker desired to mention one case that came under his observation within the last six months, and he hoped that at some future meeting of the Society he would be able to report it in detail. The patient was a man, 53 years old, a newspaper writer of national repu-

DIFFERENTIAL ETIOLOGY

Acute Retrobulbar. Acute Absorption.	Chronic. Chronic or continued.	Toxic Amb. Chronic or continued.
(A) Toxins generated within body.	do	do
(1) Toxins of infectious diseases.	do	do
(A) Acute diseases.		
(1) Influenza, diphtheria, malaria, scarlet fever, rheumatism, syphilis.		
(2) Injuries to the orbit and extension of inflammations and diseases from the accessory sinuses.		
Chronic Diseases.	Chronic Diseases.	Chronic Diseases.
	Uremia of nephritis, malaria, T. B., auto-intoxication, diabetes and syphilis.	do
(B) Absorption of toxins from without the body.		do
(1) Drugs, chemicals and metals.	do	do
(A) Alcohol and tobacco.	(A) Alcohol and tobacco.	do
(B) Lead.	(B) Lead, arsenic, carbon-bisulphide, iodoform, quinine, wood alcohol, nitro and dinitro-benzol, cannabis indica.	do
(C) Disseminated sclerosis, acute myelitis.	do	do
	do	do

DIFFERENTIAL SYMPTOMATOLOGY FINDINGS

Acute Retro-Neur.	Chr. Retro-Neur.	Toxicambly.
(1) Vision.		
(A) Rapid loss.	Gradual Loss	Uncertain vision.
(B) Loss may be partial or complete (1 week).	(B) Central Scotom for red and green—relative or absolute.	(B) Reduce Central vision. Central scotoma for red.
(2) Pain.		
(A) In orbital region and on pressure and movement of the eye.	Not present.	Not present.
(3) External appearance.		
(A) Unchanged.	Unchanged.	Unchanged.
(4) Ophthal. examination.		
(A) Hyperemia of nerve head and hazy disc margins.	Nothing abnormal in earlier stage—later templar side of disc is pale.	do
Constricted arteries and distended veins.		do
(5) Central scotoma.	Central scotoma.	Rel. central scotoma.
Early.	Later stage.	Later stage.
(6) Vision may return to normal or remain much impaired.	Diminution of field and scotoma may persist.	Diminution of field and scotoma may or may not persist.
(7) Papillo-macular.	Papillo-macular.	do
Bundle of fibers in early stage are involved—may involve entire field.	Bundle of fibers involved later stages.	do

tation, who, after attending a baseball game the latter part of October, the next morning noticed that his vision was very much reduced. This reduction in vision increased from that time until the following morning, when he was absolutely blind in both eyes. Ophthalmoscopic examination showed the media perfectly clear. Three days later neuritis developed in one of the eyes; there was quite marked swelling of one of the discs which, within two or three weeks, became very pale and there was distinct atrophy. For a period of ten days the patient was absolutely blind. There was no perception of light. At the end of about the tenth or eleventh day a little vision returned, and about a week or ten days later he was able to read; he had about 15/200 in the eye in which there had been no ophthalmoscopic changes. In the eye showing atrophy vision was afterwards about three or four feet. The man gave absolutely no history of any of the poisons that were usually looked for as productive of this condition. The Wassermann test was absolutely negative. The tuberculin test was negative. The patient had a number of healthy children, all of good habits, and the only cause that the speaker could attribute to the trouble was the possible one of so-called auto-intoxication. Following this ball game the patient and two or three of his friends went to a restaurant in a downtown district and ate a large steak, two or three inches thick, with some boiled cabbage, drank two or three glasses of beer, and really made a hearty dinner. Whether this had anything to do with the production of an acute systemic condition like this he did not know. Patient was under observation for three weeks a part of the time in the hospital, where he was examined by Dr. E. B. Hutchinson, Dr. Archibald Church, Dr. Kanavel and one or two other observers. Shortly after this the patient left the city and had been visiting with his son in Kansas City. As soon as patient returned to the city again, he would try and get his field of vision and present the history of the entire case to the Society.

Dr. Oliver Tydings said that Dr. Crossley in his citation of cases left out one of the most important, namely, next to syphilis in the production of retrobulbar neuritis was tubercular conditions. The diagnosis in some cases of retrobulbar neuritis is exceedingly difficult. In one of the first cases that came under his observation the cause was tubercular. The patient was a woman whom he saw when engaged in general practice. He operated on her for hemorrhoids, and in the course of this work he was requested to make a vaginal examination to see what was in the pelvis, as undoubtedly there was some pathology located there. The woman was almost exsanguinated from the loss of blood from the bleeding hemorrhoids. He advised operation later. He did not see any more of this woman for some years. The next time he saw her he had abandoned general practice and was going east to see his father who had been taken ill. He advised the woman to consult a surgeon. This she did, was operated on, and the report from the surgeon was that she had a tubercular right tube and ovary. Three or four years later the patient came under the speaker's observation with retrobulbar neuritis of tubercular origin, she had recovered under tuberculin therapy. He had not seen the patient since, but he sent her to a local oculist, she was treated by him, and made a good recovery under the use of tuberculin.

With regard to the Wassermann test, he was somewhat skeptical. He cited cases which destroyed his confidence in the Wassermann test. He recalled a case (which was also seen by Dr. Faith) of retrobulbar neuritis associated with other ocular conditions in which he in consultation with another was advised to remove the eye, the consultant believing it to be malignant. There was a swollen disc. The test for tuberculosis gave a reaction of one and a half degrees. The patient was put on tuberculin, got well under it, and has better than 20/30 vision in the affected eye.

Dr. Michael Goldenburg regretted that Dr. Faith was unable to show his case because he was undecided from the description whether it was one of retrobulbar neuritis, toxic amblyopia or post-neuritic atrophy. The speaker's conception of retrobulbar neuritis was that there were no ophthalmoscopic findings early, but later one could note paleness of the disc at the lower outer quadrant, the region occupied by the papillomacular bundle. In that event one would get a central scotoma

for red and green. If due to alcohol or tobacco or in deceminated sclerosis. There was hardly ever or never congestion or tortuosities of the blood vessels in retrobulbar neuritis or toxic amblyopia. One could have disturbances of the color field; in neuro-retinitis if vision was bad enough because red and green were the first colors to be lost so that central scotoma for red and green was possible. If it was toxic amblyopia, it was purely a parenchymatous degeneration. If it was a neuritis luetica it was interstitial. In interstitial neuritis antiluetic treatment would be of extreme value. In toxic amblyopia, degeneration of the parenchyma of the nerve fibers, there would be little or no improvement under antiluetic medication. If it was a toxic amblyopia on top of a luetic neuritis, the treatment for lues was indicated. The treatment for toxic amblyopia was essentially abstinence from the use of tobacco and alcohol. Injections of strychnia in conjunction with nuxvomica per os were of doubtful value. He had seen many cases get well without the local treatment. A combined condition was not uncommon. An individual, who was susceptible to excesses of alcohol and tobacco, was susceptible also to disease resulting from immorality. True cases of toxic amblyopia have a facies that is characteristic. The eyeball was not normal externally; the sclera was yellowish; the conjunctiva was yellowish, congested and appeared rough. A low grade inflammation was present in the conjunctival vessels, and by lifting the conjunctiva one would find the deeper vessels of the sclera somewhat injected.

Treatment advocated for primary optic atrophy of late was so extensive and varied and in such a state of chaos at the present time that one hardly knows what to do or say. Fuchs definitely states that primary optic atrophy usually grew worse under antiluetic treatment, yet it was resorted to right along.

Dr. Faith, in closing, stated that if toxic amblyopia was kept up for any length of time the patient would have retrobulbar neuritis, and if retrobulbar neuritis was kept up long enough there would be a secondary atrophy; it would not be the gray atrophy such as one would see in tabes. The very earliest thing to appear in some cases of general paresis of syphilitic origin was a retrobulbar neuritis. The question arose, did the retrobulbar neuritis begin by poisoning the neuro-macular bundle by the toxins of syphilis, or did it begin as a neuritis? So far as looking at the eye and examining the fundus was concerned, he did not believe any one could tell the difference except that retrobulbar neuritis was followed eventually by pallor of the whole disc if the retrobulbar neuritis went on. If one was able to arrest the process, it would end there.

In the treatment, if the toxic substance or substances were not removed, whatever they were, one could not hope to bring about a cure.

CHICAGO LARYNGOLOGICAL AND OTOLOGICAL SOCIETY.

The regular monthly meeting of the Chicago Laryngological and Otological Society was held in the East Room of the Hotel LaSalle on Tuesday evening, March 19, 1918, at 8:00 P. M.

The President, Dr. Frank Allport, in the Chair.

Presentation of Cases

DR. JOSEPH C. BECK exhibited a number of patients showing the result of plastic operations about the head and neck.

DR. ALBERT H. ANDREWS presented a paper entitled: "Turning Fork Nomenclature: A Suggested Revision." (This paper will be published in full at a later date.)

DR. JOSEPH C. BECK spoke on the subject of "Plastic Operations About the Head and Neck" and showed a series of lantern slides demonstrating many of the operations which he had performed.

He said the purpose of this talk was in line with what we might be called upon to do as the result of our entrance into the great struggle, the work of plastic surgery of major form. Not that which is found so frequently in otological and laryngological literature, but the destruction of the greater part of the face, the ear or nose and other parts about the head and neck. That which was already well established in men who had been at the front where they had been exposed to the missiles and other things which might hit them. There would be plenty of work for everybody to do in this line and it was for that reason that he wished to present the subject. It was not to show any brilliant results, for a corrected deformity was anything but beautiful, but the patient who sustained an injury to the external nose or ear was most gratified when it was corrected, even though not perfect. He had yet to see a single patient whom he had operated for external deformity of any magnitude that had attempted to sue for damages. They were invariably proud of their condition and very grateful. There was scarcely ever a patient but what came from the poorer class of people. They were mostly charity patients with no means of pay for the work that was required, and it took a great deal of work on the part of both the patient and the doctor to get anything like the desired results.

The pictures were those of a number of operations which were being followed and showed the operations which he was teaching the men in the service who would go out to do this work. He was very proud of the results obtained by some of the men who had already gone over and were doing the work he had taught them in courses in St. Louis and Chicago.

Legends of Illustrations

Slide 1. Partial destruction of the nose, corrected with Wolfe-graft, septal mucoperichondrium and cartilage reconstruction. (8 illustrations.)

Slide 2. Sub-total loss of the nose (8 illustrations). Corrected by transplantation of little finger.

Slide 3. Loss of ala, corrected by pedicle cheek flap. (3 illustrations.) Collapsed ala stiffened by cartilage transplant. (2 illustrations.) Bony costal cartilage transplant. (2 illustrations.)

Slide 4. Italian plastic from arm to nose and finger support. (4 illustrations.) Hindoo method, from forehead to nose. (4 illustrations.)

Slide 5. Temporary and permanent resection of the upper jaw. (7 illustrations.)

Slide 6. Loss of upper jaw including the lower eyelid and skin of the face, reconstructed by tunnel flap (3 illustrations). Loss of right upper and lower lip and part of chin, reconstructed by double flap (2 illustrations). Combining the tibia bone graft (2 illustrations).

Slide 7. Compound comminuted fracture of the lower jaw. (8 illustrations, showing the involvement of the fragments; interposition of bone transplant; suturing the draining; wiring the teeth and embolization of the jaw.)

Slide 8. Partial and total loss of external ear,

showing tunnel flap and temple flap reconstruction of auricle. (8 illustrations.)

Slide 9. Tracheotomy and laryngectomy. (4 illustrations.)

Slide 10. Laryngostomy. (8 illustrations.)

Slide 11. Laryngo-esophageal plastic with cartilage transplant. (2 illustrations.) Laryngectomy (5 illustrations.)

Slide 12. Complete loss of cartilaginous portion of the nose. (2 illustrations.) Partial loss of ala, skin and cartilage. (2 illustrations.) Partial loss of ala and skin including part of the cheek. (1 illustration.) Marked fistula with loss of cartilage substance of ala. (1 illustration.) Complete loss of cartilage of nose including colomela. (1 illustration.)

Slide 13. Complete loss of bone and cartilage as well as dermal portion of external nose. (Two slides, 16 illustrations.)

Slide 14. Complete loss of cartilaginous portion of the nose with marked cicatrization, involving the upper lip, corrected by artificial nose (4 illustrations). Complete loss of bony and cartilaginous portion of the nose. Skin preserved (1 illustration). Complete loss of cartilaginous portion of nose and marked retraction. (2 illustrations.) Extreme saddle nose. (1 illustration.)

Slide 15. Complete loss of colomela and destruction of cartilage following paraffin injection. (4 illustrations.) Congenital luetic destruction of the entire external nose in otherwise healthy family. (1 illustration.) Kink saddle nose (1 illustration). Plan saddle nose (1 illustration). Destruction of colomela and ala, cicatrization (1 illustration.)

Slide 16. Destruction from burn, both alae, both external ears, both lips, both cheeks and neck with marked ectropia and retraction, especially of lower lip. (8 illustrations.) Including the operation by Italian method, also showing plaster cast.

Slide 17. Loss of colomela, cicatricial contraction, Roberts operation, phalanx transplantation, reformation of nostrils. (8 illustrations.)

Slide 18. Fracture of external nose with cartilaginous transplantation (4 illustrations). Tubercular destruction of colomela (2 illustrations). Destruction of ala by electricity, corrected by Italian double transplantation method. (2 illustrations.)

Slide 19. Fracture of cartilage and bony portion of nose, corrected by fat transplant. (4 illustrations.)

Slide 20. Traumatic saddle nose corrected by rib transplant. (4 illustrations.) Saddle nose from hematoma of septum, corrected by fascia lata transplant. (4 illustrations.)

Slide 21. Traumatic saddle nose, rib transplant with infection. (3 illustrations.) Baseball saddle nose, rib transplant. (3 illustrations.)

Slide 22. Kink saddle nose, corrected by costal cartilage transplant. (5 illustrations.) Congenital absence of septal cartilage, corrected by costal cartilage transplant, including external support. (3 illustrations.)

Slide 23. Mild saddle nose, tibial graft transplant. Saddle nose following hematoma opened externally.

Corrected by costal cartilage transplant from mother to child. (4 illustrations.)

Slide 24. Traumatic saddle nose, corrected by costal cartilage transplant. Held in position by nasal saddle fixation. (4 illustrations.)

Slide 25. Mild saddle nose corrected by paraffin injection in year 1898. (6 illustrations.)

Slide 26. Hump nose corrected by intra-nasal method (4 illustrations). (2 illustrations of external method and 2 of combined external and intra-nasal method.)

Slide 27. Traumatic saddle nose and fracture of the lower margins of the orbits with fistula, corrected by costal cartilage and facial plastic (4 illustrations). Compound fracture of the nasal bones, supramaxillary and lacrimal, with tearing of the muscles by means of traction pulley. Corrected by plastic of the muscles and fixation of the fragments, tendon resection of tear duct, and fat transplant. (3 illustrations.)

Slide 28. Carcinoma of the external nose destroyed by Percy cautery and plastic reconstruction from facial falsp. (4 illustrations.) Rhinophema (2 illustrations). Rhinophema decorticated (1 illustration). Epithelioma of the external nose (1 illustration).

Slide 29. External frontal sinus wall destruction with fistula (1 illustration). Same condition corrected with fat transplant in the sinus (1 illustration). Author's osteo-plastic flap frontal sinus operation (1 illustration). Multiple operation on frontal sinus with marked deformity (1 illustration). Cerebral hernia, corrected from father to son, fascia lata (1 illustration). Cerebral hernia uncorrected (1 illustration). Cerebral hernia fascia lata transplant (1 illustration).

Slide 30. A dentigerous cyst resected and osteo-plastic flap of alveolar process obliterating it. (3 illustrations.) Oral antral fistula corrected with alveolar plastic (1 illustration). Resection of the upper jaw for carcinoma, twelve years ago, corrected by prothesis.

Slide 31. External double hair-lip and cleft palate, corrected by Lane-Ferguson method. (4 illustrations.) Adult cleft palate corrected by Author's trap-door plastic and inferior turbinated obdurator transplant. (2 illustrations.) Luetic adhesion of soft palate and posterior wall of pharynx kept apart by transplant of posterior pillar and tonsil. (1 illustration.) Ala deformity from hair-lip and cleft palate partially closed by inferior turbinated transplant. (8 illustrations.)

Slide 32. Laryngo-tracheal fistula, laryngostomy closed by Author's trap-door plastic. (2 illustrations.) Laryngotracheal fistula, laryngostomy, five attempts at closure. (3 illustrations.) (1 illustration showing hand and toe union with toe transplant to larynx.) Unsuccessful. Skin and clavicular transplant, successful. Laryngo-tracheal fissure and laryngostomy closed by Author's trap-door method. Growth of hair within the trachea from transplant. This removed under suspension.

Slide 33. Prolapsed esophagus following chondromalacia post diphtheretic. Laryngostomy, especially

devised tube to prevent contraction of esophagus into the larynx. (5 illustrations.) Laryngostomy with sub-hyoid fissure after artificial larynx implantation. (2 illustrations.) Author's hard nasal clamp. (1 illustration.) Max Joseph's orthopedic retainer (1 illustration.) Author's wire mask in a case of septal perforation, closed by middle turbinate-autoplastic. (Transplant from one patient to another.) Mask used to prevent nose being touched.

Slide 34. Facial paralysis, central origin. (1 illustration.) Facial paralysis, congenital. Facial paralysis from extreme traction on the cheek in antrum operation. Congenital facial paralysis corrected by Author's wire ceton method. Facial paralysis following application of trichloroacetic acid to Eustachian tube. Facial paralysis following removal of polyp in ear. Facial paralysis secondary to radical mastoid operation in which the entire tip of the mastoid was removed.

Slide 35. Facial hypoglossal anastomosis with tongue retaining function two weeks after operation. (2 illustrations.) Facial hypoglossal anastomosis with herpes along the course of the facial nerve. (2 illustrations.) Facial paralysis traumatic. Following pitch fork thrust external canal grazing facial nerve canal in mastoid. Simple mastoid operation, recovery. (2 illustrations.) Facial paralysis, dead labyrinth. Radical mastoid including the exenteration, recovery. (2 illustrations.)

Slide 36. Severe trauma of face, scalping with fracture of nasal bones and superior maxillae in woman aged 62 years. Immediate repair. (2 illustrations.) Traumatic absence of external ear (2 illustrations.) Faulty union after operation for ankylosis of lower jaw (1 illustration). Ankylosis of lower jaw relieved by masseter implantation between two fragments of the ramus. Author's method. Resection of large neuroma in the parotid region, closed. Cavity filled up by fat and closed by sliding flap. (2 illustrations.)

Slide 37. Large retro-auricular cavity closed by Author's trap-door and sliding osteo-periosteal skin double pedicle flap. (2 illustrations.) Retro-auricular post operative mastoid fistula communicating with external auditory canal. Closed the same way. (2 illustrations.) Retro-auricular post operative mastoid fistula communicating with external auditory canal. (2 illustrations.)

Slide 38. Giant ear. (2 illustrations.) Congenital lop ears (2 illustrations). Same condition with partial facial palsy in two brothers (1 illustration). Practically total congenital absence of external ear, three cases (1 illustration).

Slide 39. Post traumatic destruction of the greater portion of the external ear with scar on the face and side of scalp. Corrected by flap transplant from scalp, including the hair. The hair removed by electrolysis. (5 illustrations.)

Slide 40. Tubercular destruction of the external ear, including canal, thoroughly destroyed and artificial ear supplied. (3 illustrations.)

Slide 41. Lymph angioma treated with radium, 75

mlgrs. pure. This without marked benefit. Removed tumor and anchored part of the masseter in the upper lip. (7 illustrations.)

Slide 42. Malignant hemorrhagic angioma treated at five different areas. Eyelid, radium 15 mlgrs. pure. Boiling water injected into the cheek. Freezing with carbon dioxide (snow) into the region of the forehead and temple. X-ray and diathermia to upper and lower lips. Parotid region subcutaneous ligation, with complete destruction of the angioma. (4 illustrations.)

DISCUSSION

DR. FRANK ALLPORT asked how Dr. Beck felt in regard to the average curability of facial paralysis.

DR. J. HOLINGER asked whether in radical mastoid operations with the large opening behind the ear Dr. Beck would under all circumstances advise the closing? He had operated quite a large number of cases in that way, before the more modern ways were known, i. e., before 1902 or 1903 and never had heard any complaint from the patients. Furthermore, there was sometimes a niche in the bone immediately behind the entrance of the external canal, which could not be controlled from the external canal, where large masses of epithelioma and secretions might gather later on and cause trouble. He now had a patient in whom he closed the opening behind the ear at the operation and he wished he had not. The cells extended far upward and backward, leaving now a deep epidermized pocket which causes trouble regularly twice a year. He would not condemn the perpetual opening behind the ear under all circumstances.

DR. CARL WAGNER stated that he had attended the meeting instigated by the feeling that he would learn a great deal from Dr. Beck, whom he had watched develop from a boy. He felt that several things of great interest came out in the paper. It had been his privilege to watch the greatest plastic surgeon of his time, Dr. Nicholas Senn, for fifteen years, and was positive that during that time they saw hundreds and hundreds of the most wonderful achievements in plastic surgery for his time, but tonight they had seen brilliancy which he had never expected to see in his time in the presentation of Dr. Beck's patients and slides. He hoped they would go out through the United States and the whole world in behalf of those who were suffering. He was positive that if Professor Senn were living he would be glad to pay homage to Dr. Beck.

DR. BECK, closing, thanked Dr. Wagner for his complimentary remarks and said that in a paper presented before the Chicago Odontological Society he had spoken of Dr. Senn as his teacher in this work. It was his privilege to dress some of Dr. Senn's cases and he learned a great deal in that way. He was proud to say that he once received a slap from Prof. Senn for making a mistake in dressing a case. Prof. Senn was always teaching the principles of plastic surgery and would untie a stitch two or three times in order to get it just right, so that there was no tension. In his papers he brought out the points of how plastic surgery should be done.

Replying to Dr. Allport's question as to how many cases of facial paralysis were cured by anastomosis, Dr. Beck stated that he had operated fifteen cases. Of these, three had made perfect recoveries, four of the other cases were all right when in a position of repose, but when they laughed they pulled the face to the side. The rest of the cases were absolute failures, which he attributed to the fact that he operated upon them without taking into consideration the reaction of degeneration. They were early cases that were operated when he wished to do the operation and learn how to perfect it and the cases were not properly selected.

He thought Dr. Holinger's question was not well taken. He was sure the majority of the men would not wish to go back to the foul smelling, open operation. The X-ray revealed the condition before the operation and Dr. Shambaugh had shown splendid cases two years ago, showing the distribution of cells. With a good plastic operation which exposed the parts thoroughly there was nothing to fear. In the cases he had shown they simply brought the two layers of the skin

together and there was nothing that had to do with the mastoid process. They were cases which were absolutely healed. If there was a large opening left behind it was due to faulty technic or that the skin was bad.

CHICAGO LARYNGOLOGICAL AND OTOLOGICAL SOCIETY.

The regular monthly meeting of the Chicago Laryngological and Otological Society was held at the La Salle Hotel, Tuesday evening, April 16th, 1918, at 8:00 p. m.

The president, Dr. Frank Allport, in the chair.

Dr. G. W. Mosher read a paper on "Benign Neoplasm of the Nasal Septum."

While under the impression that benign new growths of the nasal cavities were not common, the author was surprised to find that Hasslauer, in 1900, found less than 300 cases on record. Of these only 115 were true new growths, and 57 of this group were angiomas. The remaining 58 were classified as papillomata, 35; fibromata, 9; myxomata, 6; chondromata, 4; adenomata, 4. From the fact that no osteomata and but four echondromata were shown in this list, it could be assumed that the investigator was very careful to rule out exostosis of the septum, as there have been a considerable number of true bony or cartilaginous tumors of the septum, as well as papillomata, etc., reported since his article was written.

As to the etiology of these growths, Kyle apparently voiced the best founded opinion by saying that like all benign tumors they had no assignable cause for existence. In contradistinction to malignant growths which commonly occur in the regions about the outer wall of the nose, benign growths usually appear on the septum, showing a predilection for the lower portion.

Clinical reports of cases, as a rule, showed no distinctive subjective findings. The concomitant symptoms, such as excess or altered secretion, hemorrhage, pain (local or referred) were usually in no way diagnostic. The exceptions included cases of angioma in which hemorrhage was the dominant characteristic and fibromata of long standing, where the growth attained such size that pressure produced deformities of the external nose or invasion of surrounding structures. In practically every case inspection and the probe made the diagnosis very easy.

Definite surgical procedures for removal had been more satisfactory than electrolysis, x-ray, radium or cautery, either actual or chemical. The extent and character of the surgical intervention naturally varied with the size and nature of the tumor mass, ranging from a simple snaring off of a pedunculated growth, with or without subsequent cauterization of the base, to a resection of the superior maxilla to give access to a growth of exceptional size involving other structures than the septum. In the septum borne growths, only simple measures were, as a rule, required. Practically no complications were reported except hemorrhage, which had not been severe and which was controlled by pressure. Fibromata had apparently caused

more trouble in this respect than any except the purely vascular growths.

The relative frequency of recurrence in fibromata and adenomata should serve as a reminder of the narrow line of separation between benignancy and malignancy, and should impress on the operator the need of thorough removal of all pathological tissue.

The author reported a case belonging in this category. The patient was a woman, aged 25 years, with negative personal and family history. A tumor mass approximately $1\frac{1}{4}$ inches long, 1 to $1\frac{1}{4}$ inches in vertical measurement, with an irregular transverse measurement, because of the manner in which it had moulded itself about the turbinated bodies, was removed from the right nares. The nasal mucous membrane showed no effect from pressure of the growth except a slight pallor and there was slight atrophy of the turbinated bodies. The patient made an uneventful recovery and there was no sign of recurrence of the growth eight months after removal.

DISCUSSION

DR. ANDREWS did not think the growths were very common, as was indicated by the author of the paper. He remembered but one in his practice and that was a papilloma, which grew from the upper part of the septum well forward. He removed it once and it recurred and after removing it a second time, it did not recur again. Two years had passed since last removal.

DR. GEORGE E. SHAMBAUGH stated that he has had under observation for several years a case of benign tumor in the nose, which springs from the ala of the nose at about the region of the limen nasi, which is the junction between the skin and the mucous membrane. The tumor was a papilloma, with rather broad base. He had dissected out a large part of it at different times, but it had always recurred. There was nothing malignant in the growth, however.

DR. GOOD had a physician, who presented a papilloma of the septum with a wide base. The tumor itself was about three-fourths of an inch up and down and half of an inch antero-posterior. He did a resection of the tumor, removed the cartilage under it and it did not recur. It was on the anterior inferior portion of the septum on the left side.

DR. MOSHER, closing, presented a slide which he thought probably some of the pathologists could throw some light on. He was inclined to take the word of the pathologist at the hospital. He considered it an adenoma. He made a section of the body of the tumor itself, but further than that he did not have a chance to talk with him about it. He just took his word that that was what it was. He was rather surprised to have heard the other men say they had seen papillomas, but not adenomas, so he was very glad to have had the privilege of presenting the case.

DR. J. GORDON WILSON presented a paper entitled: "The Effects of High Explosives on the Ear," demonstrated with lantern slides.

To the otologist an outstanding feature in the present war is the number of cases of deafness, either total or partial, occurring without any demonstrable trauma capable of accounting for the deafness and due to the burst of the high explosive shells. The force of the explosion of these shells is enormous; it may pitch a man several yards away or blow him out of the trench. The deafness is usually a combination of conduction deafness and nerve deafness, but the relative part played by the middle ear and the nerve mechanism varies considerably. Dr. Wilson has fully entered into this subject in previous years. It need only be said that the worst cases of deafness he had seen had been associated with no drum rupture and

very little apparent damage to the middle ear. In early cases the otologist often has no difficulty in diagnosing a trauma. However, the rupture of the drum or the congestion of, or the effusion into the middle ear may have been so slight that evidence of these may have entirely disappeared by the time the man gets to the base hospital.

In previous wars concussion deafness was rare. Gruber, who was otologist at the War Hospital in Vienna during the Austro-Prussian war, saw only one case. In the Franco-Prussian war in the Prussian army only twelve cases were recorded. In the Russo-Japanese war only 101 cases were recorded in the Japanese army.

The outstanding result of the concussion is the nerve deafness. The following hypotheses have been advanced to account for the deafness: (1) That there are pathologic changes in the organ of Corti and the ganglion cells; (2) that hemorrhages have occurred in the internal ear; (3) that there is an interruption in the central auditory path, due to small hemorrhages; (4) that there is a temporary interruption in the auditory path from functional disturbances not due to organic lesions. At first Dr. Wilson was inclined to lay too much importance on the fourth hypothesis, but from specimens he had examined, some of which were shown, he was inclined to think that though a number may be due to a functional derangement, there certainly were cases in which the deafness is due to an organic lesion.

The *first* series of the slides which he showed illustrated the results of laboratory experiments by Wittmaack, Yoshii and Hoessli on guinea pigs exposed to explosives. These bring the laboratory work into line with the results obtained in man. The laboratory results showed:

(1) Rupture of the tympanic membrane and hemorrhage into the middle ear.

(2) Pathological changes in the organ of Corti amounting even to complete destruction.

(3) Little or no change in the vestibular mechanism. $\frac{1}{4}$

The *second* series of slides obtained from a man who died from severe abdominal wounds forty-eight hours after injury from shell burst, showed:

(1) Intact and undamaged foot plate of the stapes.

(2) Hemorrhage into the internal auditory meatus and the modiolus.

(3) Changes in the organ of Corti—pillars and tunnel intact; edema and small cell infiltration into the basilar membrane and between the hair cells.

(4) Displacement of the tectorial membrane and its adhesion to Reissner's membrane by serous effusion.

(5) Little or no change in the vestibular mechanism

The *third* series of slides showed:

(1) Variation in the fields of vision associated with shell concussion deafness.

(2) Devices to protect the ear from shell explosives.

A very important problem to be solved is how to protect the ear against the concussion. The use of cotton does not satisfactorily block the concussion; clay impregnated with fiber cuts out all sounds and prevents the hearing of orders. The Armstrong device, which was shown, avoids both of these difficulties to a large degree, but is difficult to wear.

The device by Professor Michelson and the Doctor, which also was shown, appeared to the members to answer all requirements. Laboratory experiments with pistol shots showed that it protects animals perfectly and what is of importance, acts more effectively the higher the explosive force.

DR. SHAMBAUGH said certain facts had long been recognized in regard to the relation between injuries of the internal ear resulting from explosions and injury of the drum membrane. Where the drum membrane had been ruptured the injury to the internal ear is usually less; or in other words, the cases where the internal ear had been most severely injured had been cases where the drum membrane had remained intact.

In regard to the actual injury which is sustained in the labyrinth of the ear as the result of explosions, the facts in regard to these injuries have only rather recently been ascertained. Examinations made of human material have not as yet thrown any light upon this interesting problem, for a reason which anyone who had worked histologically with the internal ear understood. It was not possible to secure in human material that fixation which is necessary to prevent the development of artefacts which resemble so closely the changes produced in the organ of Corti by explosions. In order to get the proper fixation it is necessary to inject fixing fluid into the circulation either before or immediately after the death of the individual. This work can only be done with animals. In the specimens exhibited, it was impossible to say whether all of the changes were due to faulty fixation or not.

If a pistol was shot or exploded close to the ear of a guinea-pig and then the labyrinth immediately removed with proper fixation one can always recognize certain definite distortions in the cells which make up the organ of Corti. If after this experiment the guinea-pig is killed, say after a month or two, one or two things present themselves: Either the organ of Corti has undergone a degenerative process in which the specialized epithelium has become flattened, or a complete regeneration of the distortions caused by the explosion has taken place. These facts have been definitely worked out and explain exactly what is met with clinically. In cases where the ear has been injured by an explosion, not infrequently the deafness remains permanent. In other words, the organ of Corti undergoes degeneration. In some of the cases, perhaps where the injury had not been so severe, a regeneration of the organ of Corti takes place and there is a gradual return of the hearing function. Dr. Shambaugh remembered very distinctly when Dr. Wilson first returned and expressed the view that the injury to the hearing was the result of intracranial lesions, so he called his attention to the work which had been carried on by Siehermann and expressed the view that he did not see any reason for assuming an intra-cranial lesion as the cause for the defect in hearing, when it was perfectly well known what took place in the labyrinth itself. It seemed that Dr. Wilson also took this point of view later on.

He was very much interested in one of the observations which Dr. Wilson had made, namely, that in these cases of concussion with deafness there was also some vertigo, and yet from the examination of histological preparations no injury could be detected in the end organs of the vestibular nerve; that is, in either the macula acoustica or the crista acoustica. He also asked Dr. Wilson whether he had had an opportunity of observing any of these cases while they were still having this so-called vertigo and whether he had observed any of the characteristics of vestibular vertigo and especially whether there was any spontaneous nystagmus. Patients have often said that they had vertigo, but when it came time to question them more closely, it was found that they were not really suffering from

vertigo at all but were using the term vertigo rather loosely to express other indefinite sensations.

DR. HOLLINGER said the questions Dr. Wilson discussed in his paper were treated experimentally, and very definite results published in a book illustrated with many excellent drawings by Professor Liebermann and edited by Benno Schwabe Basle, 1917.

DR. ANDREWS said it was very interesting to note the position of the tectorial membrane in the cases of injury in the specimens which Dr. Wilson had shown. Following injury it was well up against Reissner's membrane and in Dr. Wilson's specimens it was apparently attached to it. The position of the tectorial membrane may have had something to do with the permanency of the impairment of hearing. It was possible that its becoming attached to Reissner's membrane may have had something to do with the permanency. Of course, this was solely a suggestion.

(To be continued)

Personals

Dr. and Mrs. S. T. Robinson, of Edwardsville, are spending the winter in Long Beach, California.

Captain C. F. Burkhardt, of Effingham, councillor of the seventh district, has been honorably discharged on account of physical disability.

Dr. T. D. Doan, secretary of the Macoupin County Medical Society, has accepted a position on the medical staff of the Kankakee State Hospital.

Dr. Henry F. Hooker, Danville, has been appointed local physician and surgeon to the Illinois Traction Company, to succeed Dr. George Steely, who has resigned to enter the military service.

Dr. Edward F. Garraghan has been appointed attending laryngologist at Cook County Hospital, to succeed Dr. Joseph C. Beck, who is at present commandant of the Czecho-Slovak Hospital in Cognac, France.

Dr. Emilius C. Dudley, after thirty-seven years as professor of gynecology at Chicago Medical College and Northwestern University Medical School, has retired from the faculty and has been made emeritus professor of gynecology. In commemoration of his long and faithful work for the school, the faculty gave a dinner in his honor, December 12, at which Dr. Archibald Church, Chicago, presided and at which addresses laudatory of Dr. Dudley were made by President Holgate of the Northwestern University, Dr. Wm. E. Quine, Dean Arthur I. Kendall, Major Samuel C. Stanton and Lieut.-Col. Nathan William McChesney.

Dr. Hugh McKenna, officially speaking, Lieutenant Colonel McKenna, has returned from the

army service to his former position as president of the staff of St. Joseph Hospital. Dr. McKenna entered the service in October, 1917, as Chief of Surgical Service at Camp Pike Base Hospital, Arkansas, and was later promoted to the rank of lieutenant colonel and transferred to General Hospital No. 22, Richmond, Va., as Chief of Surgical Service. The doctor had quite an extensive service in chest and abdominal surgery. He has now resumed the practice of surgery in Chicago.

News Notes

—The Weirick Sanitarium, Rockford, for the treatment of drug and liquor addicts, formerly the Broughton Sanitarium, is reported to have been closed.

—A fire at the Dunning State Hospital, December 11, did great damage to the tuberculosis building, a one-story frame structure, from which 400 patients were removed, many of them ill with influenza. No casualties occurred.

—Fire of unknown origin at Camp Grant, Rockford, is said to have destroyed the building occupied by the medical examination board handling discharge examination work, and it is said that 6,000 qualification cards and records of examination were lost.

—At the annual meeting of the North Central Illinois Medical Association held in Dixon, November 10, Dr. Otho B. Will, Peoria, was elected president; Dr. John C. White, Seatonville, vice-president, and Dr. George A. Dicus, Streator, was re-elected secretary-treasurer.

—The Chicago Tuberculosis Institute gave a luncheon at the Hotel La Salle, December 11, at which Dr. Robert H. Babcock, Chicago, presided, and Dr. Donald B. Armstrong, Framingham, Mass., gave an account of the Framingham Community Health and Tuberculosis Demonstration.

—Thirty-four nurses enrolled in a newly formed labor union at the Municipal Tuberculosis Sanatorium, Chicago, recently. The union is affiliated with the Federation of Labor, a charter having been secured through the president of the Woman's Trade Union.

—The Kewanee Physicians Club at the annual meeting in Danville, December 3, elected the fol-

lowing officers: President, Dr. G. P. Noren; vice-president, Dr. C. A. Coffin; secretary-treasurer, Dr. John Boswell. The influenza situation was the principal subject for discussion.

—Dr. Bertha C. Day Raymond of 2675 East Seventy-fourth street was arrested by the Department of Registration and Education of the State of Illinois, December 3, on the charge of practicing medicine without a license. She pleaded guilty in the municipal court of Chicago and was fined \$25 and costs.

—The Vermilion County Medical Society, at the meeting December 3, elected the following officers: President, Dr. J. P. James; vice-president, Dr. L. L. Steiner; secretary-treasurer, Dr. J. G. Fisher; state delegate, Dr. F. N. Cloyd; censor, Dr. A. F. Leitzbach; alternate censor, Dr. O. H. Crist.

—At a recent meeting of the Morgan County Medical Society the following men were elected to office: President, Dr. Edward Canatsey, Jacksonville; vice-president, Dr. W. L. Frank, Jacksonville; secretary, Dr. H. A. Chapin, Jacksonville; treasurer, Dr. A. L. Adams, Jacksonville; censor, Dr. A. J. Ogram, Jacksonville.

—The Chicago Bureau of Public Efficiency is said to advocate the abolition of the office of coroner of Cook county and to have the duties performed by medical examiners of the state board of health. As the office is a constitutional one the change will be presented for action at the constitutional convention. Recent disclosures that certain coroner's physicians appeared in court, both as representatives of the coroner and of private interests, have focused attention on the office.

—Dr. Samuel R. Harwood of East St. Louis, whose license to practice medicine and surgery in the state of Illinois was revoked some three months ago, has promised the authorities of St. Clair county that he will leave the state if they will permit him to plead guilty to one of the eight indictments returned against him by the grand jury of that county and pay a fine of \$500 for obtaining money under false pretenses. His offer has been accepted by the state's attorney. The eight indictments returned against Harwood for practicing a confidence game and obtaining money under false pretenses were returned by the

grand jury of St. Clair county immediately following the revocation of his license.

Marriages

ALOYSIUS JAMES LARKIN, Melvin, Ill., to Miss Florence Mary Garvy of Chicago, September 4.

HUGH QUITMAN ALLISON, Lieut., M. C., U. S. Army, Grayville, Ill., to Miss Bessie Williams of Mount Carmel, Ill., at Belleville, Ill., February 8.

ASST. SURG. HARDY VERNON HUGHENS, Lieutenant, U. S. Navy, on duty at Great Lakes, Ill., to Miss Agatha Alethea Roemer of Waukegan, Ill., November 28.

Deaths

WALTER CHARLES PAINE, New Holland, Ill.; Rush Medical College, 1895; aged 52; died at his home, October 13, from pneumonia, following influenza.

GEORGE W. McDOWELL, Rockford, Ill.; Hahnemann Medical College, Chicago, 1889; aged 52; died at his home, November 22, from myocarditis.

EUGENE MARTIN, Chicago; University of Illinois, Chicago, 1889; aged 62; died at his home, November 23, from nephritis.

ROBERT ALEXANDER McCLELLAND, Yorkville, Ill.; Rush Medical College, 1878; aged 64; a Fellow A. M. A.; died at his home, November 29, from cerebral hemorrhage.

GEORGE W. CALDWELL, Waggoner, Ill. (license, years of practice, Illinois, 1877); aged 84; for sixty-three years a practitioner of Montgomery County, Ill.; died at his home November 28.

ALBERT CHARLES D'VORAK, Chicago; University of Illinois, Chicago, 1918; aged 32; an intern in Michael Reese Hospital, Chicago; died December 6, from pneumonia.

JAMES ELWIN SNYDER, Versailles, Ill.; Chicago College of Medicine and Surgery, 1912; aged 44; died in Cooperstown, Ill., September 17, from carcinoma of the stomach.

WILSON B. SHELTON, Bingham, Ill. (license, years of practice, Illinois, 1888); aged 75; a member of the Illinois State Medical Society; and a veteran of the Civil War; died at his home, November 4, from cerebral hemorrhage.

HENRY NICHOLAS BARTH, Metamora, Ill.; Northwestern University Medical School, Chicago, 1909; aged 33; a Fellow A. M. A.; a specialist in internal medicine; died at his home, November 18, from septic endocarditis.

WILLIAM JOHNSTON CALHOUN, St. Charles, Ill.; University of Pittsburgh, 1891; aged 56; a Fellow

A. M. A.; health officer of St. Charles; local surgeon of the Chicago Great Western System; died at his home, December 9, from pneumonia.

MALCOLM DONALD MACNAB, Chicago; Rush Medical College, 1895; aged 47; at one time a member of the Illinois State Medical Society and Physicians' Club of Chicago; died at his home, November 27, from a gunshot wound.

HENRY T. WATKINS, Olney, Ill.; Hahnemann Medical College, Chicago, 1883; aged 58; a Fellow A. M. A.; founder and proprietor of the Olney Hospital; died on a train between Vincennes and Washington, December 4, from heart disease.

LIEUT. MALCOLM CUNNINGHAM, M. C., U. S. ARMY, Chicago; Chicago College of Medicine and Surgery, 1917; aged 25; a Fellow A. M. A.; on duty with the 76th Spruce Squadron, Astoria, Ore.; died at his post, October 8, from pneumonia following influenza.

JOSEPH S. GENTILE, Chicago; Chicago College of Medicine and Surgery, 1913; aged 33; a member of the staff of the Columbus Extension Hospital; who was shot, December 14, by a patient whom he was called to attend; died in the Columbus Extension Hospital the following morning.

JOHN CALVIN McCLURKIN, Chicago; Bellevue Hospital Medical College, 1871; aged 78; who was operated on November 14 for cataract, jumped from a window in St. Luke's Hospital, November 24, sustaining injuries from which he died shortly after.

JAMES CORBETT RATHBUN, Danville, Ill.; Bennett Medical College, 1909; aged 37; a member of the Illinois State Medical Society; while driving across the interurban tracks in Danville, November 13, was struck by an interurban car and instantly killed.

GEORGE JOSEPH SPENCER, Chicago; University of Illinois, Chicago, 1908; aged 41; at one time a member of the Illinois State Medical Society; city physician of Chicago in 1911; who was in government service in Albany, N. Y.; died in that city, December 6, from pneumonia.

ELDORA ALICE THOMAS, Chicago; University of Illinois, Chicago, 1913; aged 33; for several years a medical missionary in Sierra Leone, West Africa; more recently house physician at the University Hospital, Chicago; died in that institution, November 26, from valvular heart disease.

LIEUT. ARTHUR FRANCIS MCQUAID, M. C., U. S. ARMY, Chicago; Loyola University, Chicago, 1915; aged 28; a Fellow A. M. A.; on duty at British war hospitals in England from October, 1917, to July, 1918, and since that time serving with the British Expeditionary Forces in Flanders and France; is reported to have been killed in action, October 15.

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Original Articles

THE TREATMENT OF INTESTINAL STASIS.*

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It is not the purpose of this paper to consider the diagnosis and etiology of so-called auto-intoxication, but rather to deal with its clinical aspects and to present the experiences of myself and colleagues at the Chicago Therapeutic Institute in our efforts to relieve this distressing condition by various methods and procedures during the past ten years.

Before taking up the discussion of details and treatment, it might be well to state that we have made it a practice to give every patient going through our hands for a complete examination a thorough-going bismuth meal and x-ray observation. As a result of this routine investigation, we have discovered that it is not sufficient to take the patient's word that the bowels move freely once or twice a day as constituting evidence of normal intestinal elimination. The x-ray shows that many such patients are suffering from stasis and that, while the bowels move regularly once or twice a day, they are like the proverbial Missouri Pacific passenger train—they are from one to two days behind time.

Clinical classification. From the standpoint of treatment, intestinal stasis may roughly be divided into the following five classes:

1. Spastic Stasis.
2. Atonic Stasis.
3. Dietetic Stasis.
4. Mechanical Stasis.
5. Habit Constipation.

I am aware that this classification may not be scientifically and technically correct, but it is a very practical one from the standpoint of ar-

ranging, prescribing and carrying out treatment, and I would like your indulgence to the extent of allowing me to discuss the treatment under these five respective heads, though I think it best to consider the general principles of managing stasis and its resultant auto-intoxication before we take up the treatment of these special classes.

In this connection, it might also be further stated that more than 75 per cent of these chronic cases of intestinal toxemia also present for consideration a clinical acidemia. In the study of these cases it has been our custom to group all of these attending features on one graphic chart; and they are detected by means of the well-known acidity and indican tests of a fresh specimen of urine and, still better, by the more recent methods of determining the carbon dioxid tension in the alveolar air, not to mention the salivary acidity, gastric acidity, etc.; and, of course, these clinical findings are taken care of temporarily by alkalies and permanently by prescribing a diet whose residual ash is 65 to 70 per cent alkaline.

General Management of Auto-intoxication. It is probably needless to say that all cases of intestinal toxemia should have as a part of their general treatment thorough-going eliminative measures, such as the sweating procedures of the electric light bath or some other equally efficient treatment. The basic methods of general application to most all phases of chronic constipation and its associated toxemia and those which we have long employed as the foundation procedures in the management of these troublesome conditions are the following:

1. Dietetics. Give abundance of liquids. One glass of cold water is taken immediately on rising each morning. See that the patient takes at least eight glasses of liquids during each day. Use bran bread or bran systematically, together with the free employment of other forms of relatively indigestible cellulose, such as wheat flakes, asparagus, cauliflower, spinach, sweet potatoes,

*Read before the North Side Branch of Chicago Medical Society, November 8, 1918.

green corn and popcorn, graham flour preparations and oatmeal foods, whole wheat preparations, bran bread, apples, blackberries, cherries, cranberries, melons, oranges, peaches, pineapples, plums, whortleberries, raw cabbage, celery, greens, lettuce, onions, parsnips, turnips, lima beans and peanuts.

These coarse vegetable foods, of course, cannot be freely employed in those cases of stasis which are accompanied by alternating attacks of colitis.

Meals must be taken regularly. Food is a physiologic laxative and a stimulus to peristalsis. About the same amount of food should be taken at each meal in order to establish intestinal rhythm. Eat at the usual time—even if only fruit or bran is taken.

2. Mineral oil and paraffin. We have discarded all forms of laxatives and cathartics—except in the early days of a course of treatment, when we sometimes use cascara. Mineral oil is not a laxative—it is simply a lubricant and agrees with nineteen patients out of twenty.

These paraffin substances used either in liquid or solid form (and there's very little choice between any of these preparations from the standpoint of efficiency), given before meals in doses anywhere from one to four tablespoonfuls, are invaluable aids in combating intestinal stasis.

3. The moist abdominal bandage (Neptune's girdle) should be used in many cases. The patient must be instructed how to put it on and take it off. The linen girdle next to the skin is wrung out of ice water and applied snugly about the belly at bed-time and covered with mackintosh or other impervious material; cover both these with two layers of flannel, which is snugly pinned on. Unless the patient is undergoing treatment in mid-winter, we quite generally use this procedure and have them continue it for from three to six months. It should be added that this linen cloth which goes next to the skin must be thoroughly cleansed by boiling at least twice a week or oftener to avoid skin eruptions—the "humors" of the old-time empirics.

4. Regular habits of stool. Train your patient to go at least twice a day to evacuate the bowels, with the feet elevated on a high foot stool, so as to get the squatting position of former generations. I am about to come to the conclusion that any one whose bowels do not move oftener than once a day is suffering from mild

intestinal stasis. A study of my patients, as well as the animals in the zoo, has confirmed me in this belief, that there should be a bowel movement corresponding with every meal eaten.

Eating starts up intestinal peristalsis, and so it is a good practice to go to stool immediately after each meal.

5. Massage and electricity. Scientific massage and manual Swedish movements are invaluable in overcoming colonic stasis. The only form of electricity I have employed in recent years is the sinusoidal current. I regard other forms of electricity of very little value. A valuable method of employing electricity is to fill the rectum and lower colon with water, insert one pole and apply the other pole to the abdomen by means of a generous electrode. We employ the sinusoidal current in this way with great benefit.

6. Hydrotherapy and phototherapy. It would require a paper much longer than this to go into the details and to show the nervous mechanism involved in the results that are obtained by the use of hot and cold to the abdomen, are light to the spine, etc., Hydrotherapy we regard as one of the most highly efficient procedures to be employed in combating auto-intoxication, both locally and constitutionally. The use of hydrotherapy must be adapted to the individual case, but it is almost the sheet-anchor when it comes to getting those early results which are so essential to the patient's encouragement. Many cases are wonderfully helped by hot and cold (fomentations and ice) applied to the lower spine—five or six changes—beginning with hot and ending with the cold.

7. Exercise. Leg and trunk exercises tend to strengthen the abdominal muscles, together with the proper amount of walking each day. These exercises should be a part of the regular routine management of chronic constipation. Both active and passive exercises may be employed—according to the patient's strength and the nature of the case. Horseback riding and deep breathing exercises are of great value. During the past ten years we have worked out a systematic course of exercises—too elaborate to undertake to describe in a brief paper—but the following procedures constitute the foundation of the exercise regime, which must, of course, be properly adapted to each patient's individual condition and needs.

Whatever the treatment of constipation, it must be *daily*; irregular and desultory methods will not produce results.

A. Exercises in the standing position:

1. Deep breathing. With hands on hips, forcibly extend the abdomen as you breathe in through the nostrils. Whistle the breath out through the mouth and before you breathe again lift the chest high.

2. Auto-massage. Press in the abdomen near the right hip bone, and with the abdominal muscles throw the hands upward. Press three times over each surface and work upward over to left and down to left hip bone.

3. Leg raising. Stretch legs downward and slowly raise and lower—take alternately and together.

4. Trunk raising. With hands on hips come up to sitting position and go back to lying.

5. Chest raising. Turn face down and lift the chest—hands remaining on hips.

B. Exercises in the sitting position:

6. Trunk circumduction. Hands on hips, eyes straight ahead and feet separated. Make a complete circle of the trunk from right to left six times, and reverse.

7. Liver squeezer. Take position No. 6 with hands on chest. Twist body to left and bend to right. The right elbow should glide past the right knee. Reverse.

These exercises are a part of the home treatment of stasis in which the patient must be thoroughly instructed, as much depends on their faithful and intelligent co-operation in these important details.

8. Mechanical Swedish movements and vibration:

These mechanical movements are all more or less valuable, especially have we had good service from the abdominal kneeder, mechanical horse and the tissue oscillator. The co-called roller reducer has proven of very little value in these cases.

Mechanical vibration must be managed by an expert to be of service in helping chronic constipation. I am of the opinion that the indiscriminating use of the vibrator, whether on the part of the physician or layman, has done more harm than good. I regard this method of treatment as the least valuable of all the different methods of treatment tried during a careful study of this

subject for the past dozen years. Today, the vibrator with us is practically limited to use in connection with the dilatation of the rectal sphincter, which can be thus effectively carried out without the use of an anesthetic.

9. Bulgarian culture. I have not found the buttermilk cure of great value, although I do regard it as a help and never fail to make it a part of my regime, though I have come to regard the employment of the Bulgarian culture in connection with the mild sinusoidal current as a highly efficient method of treatment in many selected cases of chronic stasis. After the administration of a cleansing treatment to the colon, the Bulgarian culture is slowly injected, and when the bowel is well filled the sinusoidal current is applied by the technique already described, and in proper measure, and thus the culture is thoroughly massaged into every nook and corner of the colon. Without the use of this sort of electric-massage procedure we do not get satisfactory results from the injection of the Bulgarian culture in the bowel. We have used radium, but so far have not found it to be so beneficial as the Bulgarian culture with the sinusoidal current.

The development of the treatment of intestinal stasis has reached that point today where, after the proper investigation and diagnosis, practically every patient can be promised more or less complete relief, if they will submit to the requisite medical or surgical procedures indicated in their individual cases.

The time required to bring about the cure of most of these non-surgical cases runs anywhere from three weeks to three months, depending largely upon the chronicity and gravity of the disorder and the enthusiasm and faithfulness with which the patient enters upon and carries out the prescribed regime.

Having thus outlined the general management of auto-intoxication, let us next take up the special treatment of the various forms or phases of this common disorder.

Spastic Constipation. This form of intestinal stasis is found in patients who have an active nervous temperament and in those who have a tendency toward colitis, or the so-called old-fashioned catarrh of the bowels. These cases are not only greatly benefited by the use of mineral oil and bland unirritating foods, free from

cellulose and high seasoning and spices, but are also greatly helped by hot applications over the abdomen and by the use of the oil enema in hemorrhagic mucous colitis. Water enemas should not be given these cases, unless the water is rendered markedly alkaline by the addition of soda. Colonic flushings are contra-indicated, as is also heavy abdominal massage, although the mild sinusoidal current is sometimes highly effective.

Sometimes this spasticity is limited to the sphincter muscles of the rectum; in other cases it is probably the result of rectal fissure or ulcer or painful hemorrhoids. Dilation of the spincter under anesthetic or by the cone dilator attached to a hand vibrator will sometimes, without further treatment, practically bring about the cure of a case of spastic constipation. It is sometimes necessary to dilate two or three times.

Atonic Stasis. This is the group found in the states of nervous exhaustion and neurasthenic collapse; in the case of those who have had a colitis tendency, but who are now in the second stage of their intestinal troubles. I may say in this connection that I have come to regard "nervousness" as more frequently being the cause of constipation than as resulting from intestinal stasis. It is also found in many cases of enteropitosis where there is a general sag of the abdominal viscera, and in some of those cases of chronic "biliousness," bad breath, coated tongue, etc. This is the group of cases shown up so well by the x-ray studies and which are benefited by the increasing of roughage in the diet, as well as by the use of mineral oil. These cases are greatly helped by the alternating hot and cold applications to the abdomen, accompanied by vigorous massage or manual Swedish movements. Mechanical vibration and mild sinusoidal electricity are also helpful in treating and stimulating intestinal peristalsis.

These cases are also greatly helped by the use of Neptune's girdle, or the moist abdominal bandage, already described under the general regime of handling chronic constipation.

Many of these cases with relaxed abdomens are greatly benefited by wearing a properly fitted support or hammock sling of some sort.

Dietetic Stasis. Intestinal stasis as related to diet may be divided into two groups: First, those cases in which the chief fault is the ingestion of too small a quantity of liquids, in which event

paraffin oil and agar are exceedingly beneficial. The employment of Japanese seaweed, which, being indigestible, carries moisture throughout its long journey through the alimentary canal, is very helpful in cases of this class. Of course, these patients are encouraged to drink abundance of water, taking it in small quantities every half hour or hour throughout the day.

The second group, under the head of dietetic constipation, is where the food contains too little bulk, where the diet is too concentrated. These are the cases which are peculiarly benefited by the addition of cellulose and other indigestible roughage to the diet of each meal. These are the patients who should have bran bread, sauer kraut, spinach, turnips, etc., not to mention the more laxative sour fruits, such as apples, oranges, etc., and also the highly laxative fruit sugar eatables, such as figs, raisins, etc.

These are the cases of constipation and associated auto-intoxication that can be cured easily by the regulation of the diet, but they represent only a minority group in the total number of sufferers from intestinal toxemia.

Mechanical Stasis. The cases of constipation falling under this head may also be largely divided into two groups: First, those suffering from the intestinal adhesions, kinks, loops, etc., those who have an extra large pelvic loop in the colon, a condition which we hardly recognized until the recent years of x-ray investigation of the digestive tract. Under this head, also, belong those who have a dilated cecum, a "cecum mobile" of Wilhms. While these cases are helped by massage, hydrotherapy, electrotherapy and suitable exercises, nevertheless many of them are surgical, and a trip to the operating room is necessary to cure them. This is particularly so where there are post-operative or tubercular adhesions. In fact, we have come to recognize a veritable group of "surgical stasis," embracing gall-bladder diseases, chronic appendicitis, diverticula, Jackson's membrane, Lane's kink—not to mention the more recently discovered condition of incompetent ileocecal valve. How often we see a case of chronic constipation entirely cured by an appendectomy!

In the second group under this head we have to deal with an incompetent ileocecal valve. We have been quite surprised in recent years to find how many people have incompetency of the ileocecal valve, though we have not, for some reason,

found this condition to be present to the extent that some observers have. This is one of the real satisfactions of the three-day bismuth meal, properly checked up with the second filling meal and clyster. I have never yet found it necessary to operate upon a patient for the sole purpose of correcting an incompetent ileocecal valve, but it seems unfortunate that a patient having an incompetent ileocecal valve should undergo abdominal surgery for any cause such as appendectomy and have the abdomen closed up without the least effort being made to correct this condition, when it is usually so easily remedied by the insertion of a couple of linen sutures.

Checking up these cases with the x-ray, the operation for this incompetency is found to be almost universally successful, and the patient's tendency to constipation is always relieved or entirely removed, depending on the extent to which it was a factor in producing stasis.

Cases of mild incompetency of the ileocecal valve are greatly helped by massage, exercises and electricity—in fact, by anything that encourages peristalsis.

Everything must be done in these cases to encourage and promote vigorous and normal peristalsis, as our attention has recently been called to the fact that certain individuals have reverse peristalsis who are not even suffering from incompetency of the ileocecal valve.

Habit Stasis. The last group of intestinal stasis is due solely to habit. Neglect of the call of Nature is responsible for many cases of chronic constipation which come to the physician seeking relief. Regular habits at stool, dilation of the rectum, a cellulose diet and suitable exercises will afford early relief. In fact, many cases are cured by going to stool twice a day for a week or two, without any other treatment, when they are not of too long standing.

Attacking the Intestinal Flora. This paper has not afforded the opportunity to go into discussions regarding the intestinal flora, which are responsible for the production of those toxins which are at the bottom of so-called auto-intoxication. I might add, in closing, that we have found it very necessary to restrict the protein in the diet of these cases, particularly the animal protein, and that we have further found a fruit diet in the vast majority of cases to be highly

beneficial both in overcoming intestinal stasis and in relieving the acidemia, which is such an ever-present feature in most cases of intestinal poisoning.

In the last year or two we have come to look upon the employment of an exclusive milk or milk and fruit diet as constituting the best possible means of bringing about a more or less permanent and favorable change in the intestinal flora. Years ago I discarded the milk diet as being a failure in these cases, and I so regarded it to the present day. On the other hand, I have in the last year or two come to recognize the "milk regime," as taken from the recommendations of Tissier and others, to be of great value. A typical feeding program as practiced by these authorities and which we have found to be very helpful in many cases, will be found to be very different from the so-called milk diet, and is carried out in harmony with the following plans:

1. Patients are given from six to twelve pints of milk every 24 hours, following a period of two days' exclusive fruit diet.

2. Milk is given at 24 feedings, starting at 7 a. m., four to eight ounces being taken every half hour until 7:30 p. m.

3. At 7 a. m. fruit, bran and mineral oil are substituted for the milk, also at 3 p. m.

4. At 10 a. m. and at 7 p. m. bran and mineral oil are given in addition to the regular milk meal.

5. When the patient desires, lettuce and celery may be given in connection with one or both of the fruit meals.

6. In starting this regime it is best to give the milk at hour intervals for a day or two, gradually reducing the time to 30-minute periods.

7. The amount of milk taken daily must depend upon the capacity of the patient. It is clearly necessary to take fully double the amount of milk actually needed for nourishment. The ratio of body weight is about one and one-half ounces of milk to each pound of body weight.

I am coming to regard this plan of milk feeding as one of our most valuable methods of bringing about a desirable change from the "wild" toxin-producing bacteria of the intestinal tract to the less harmful and more "friendly" group of organisms that belong to the lactic acid forming family of microbes.

MEASLES A PREDISPOSING FACTOR TOWARDS PULMONARY TUBERCULOSIS.

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A review of the medical literature of the past fifty years brings to light a number of interesting theories relative to the etiology and predisposing factors of pulmonary tuberculosis. We find the French literature of thirty and forty years back, especially the monographic forms, prolific in the theories of causation of pulmonary tuberculosis. In the American and English literatures of the same period, we find numerous papers by men of recognized ability centered about that all-absorbing interesting phase of medicine. The theories advanced are as varied as they are numerous, some logical and well-founded, others radical and amusing. After the discoveries of Villemin in 1865, and of the tubercle bacillus by Koch in 1882, these theories, at least many of them, were not abandoned, but merely modified, and directed towards the predisposing factor in pulmonary tuberculosis.

So that in the decades of 1880-1890-1900, we find the medical literature again theorizing, not on the etiology of pulmonary tuberculosis, for that was now definitely established; but on the "diathesis," the "weakening influence," the "predisposing causes." All the many theories advanced and given a varied degree of credence will admit of a rough classification into two large groups:

A—Infectious and contagious diseases.

B—Environment (which must include heredity).

Of the infectious and contagious diseases, few, if any, were slighted. Oddly enough, the minds of medical writers, especially those interested in phthisio-therapy, seemed to follow one lead after another, in their Will-O-the-Wisp chase of a real definite logical predisposing factor of the dread disease whose etiology had at last been established. So that for a few years, one disease after another bore the brunt of scientific research, and in due time received its share of condemnation, and was labeled a dangerous, much to be feared infection, a prurunner of tuberculosis, an open-sesame to the tuberculosis diathesis.

The diseases of the respiratory tract, influenza, bronchitis, pneumonia and pleurisy were quite

logically eyed with suspicion, and even today we recognize the indisputable fact that any cause which tends to weaken or impair locally or generally the respiratory system, naturally is a lurking enemy. But other theories less logical were advanced, diseases and infections in no way connected with the respiratory system came under suspicion, until the list included typhoid fever, malaria, mumps, chickenpox, smallpox, scarlet fever, diphtheria and diseases ad infinitum.

One of the most interesting, for several reasons, of all the various diseases and conditions exploited as a predisposing factor towards tuberculosis, is measles. For fully fifty years, in fact, from the time that measles was recognized as an infectious disease, and attained a true identity, it was associated by the profession and the laity alike with pulmonary tuberculosis. Its first point of interest then arises from this fact—its popularity, its general belief. No disease and no other theory, not even that of heredity, gained such credence, and was so widely acclaimed as was measles. The why and wherefore of this belief leads us into interesting channels. That heredity should appeal to the lay and even professional mind as a predisposing cause, is easily understood.

Or that pneumonia, or any of the respiratory diseases which by their weakening, attenuating influence logically predispose, should be considered, is clear. Or environment, the sound logical, sociological argument, but measles—why measles? And yet measles, a rather mild, inoffensive infectious disease, running a ten day febrile course, with slight skin manifestations, some general and gastrointestinal disturbance, and, as a rule, a negligible bronchitis complication, held the place of honor amongst all the theories of predisposition.

Early in 1918 the Surgeon General, through Col. George E. Bushnell, ordered an investigation of just this problem, the relationship of measles to pulmonary tuberculosis. Because of the fact that a considerable number of measles cases had developed in several camps, the opportunity for this bit of research was ideal. Not only were the measles cases available for examination, but because these subjects were soldiers in training, they presented the opportunity of re-examination at various subsequent dates. One such survey was carried out at Col. Bushnell's direction at Camp Grant, Ill., and it is the purpose of this paper to review the procedure and tabulate the results.

The work was begun during the first week in February, 1918, and extended over the following seven months to September 1. Only frank cases of measles with a diagnosis based on a typical skin eruption, Koplick's spots and leukopenia were included. With the exeception of a few stray eases all the subjects had been examined for tuberculosis within a month or two, previous to their entrance into the base hospital with measles, at the time of their induction into serviee, and their reecords kept on file at the Tubereulosis Clearing Station;* this roster forming a complete and thorough cheek. As soon as a frank case of measles was admitted into the base hospital, notifieation was made to the Clearing Station by the Isolation Department of the base hospital, giving date, name, rank, organization and diagnosis.

In the Clearing Station by means of a daily file, the admittance date of each measles ease was registered. Two weeks following admission, a thorough ehest examination was made and findings noted. This comprised the first examination. Thirty days later, or approximately six weeks after admission into the hospital, the case was re-examined and the findings of this second examination noted. A speeial blank was prepared, on which the findings were kept.

Form used for physical findings of first and second examinations following measles:

Name..... Age..... Company.....
Regiment
Address
City..... State.....
Measles.
Date of First Symptom.....
Date of Hospital Admission.....
Date of discharge
First Examination.....1918.
Lung Findings:
.....
Signature of Examiner.....
Second Examination.....1918.
Lung Findings:
.....
Signature of Examiner.....

This form provided at once a careful record and a comparison between the findings of the first and second examinations. So that the files at the Tubereulosis Clearing Station provided

a record of the examination of the soldier as a recruit at the time of his induction into serviee, and by means of the measles blank, provided also a detailed reecord of his two later chest examinations following measles.

This procedure, while not perfect, worked reasonably well. Difficulties, many of them, were encountered. For example, when notification was sent a company commander that Pvt. A be sent to the Clearing Station for tuberculosis examination, the answer would occasionally be, "A is overseas." But this was the exeception rather than the rule, and less than three per cent failed to return for this second examination.

The survey proved highly interesting and instructive, not alone because of the rather startling figures and results attained, but also because it provided an opportunity for studying a large number of chests, a great percentage of which showed a type of bronchitis a little different from that ordinarily encountered. In all, 596 eases of measles were examined, the first time 14 days after admission into the hospital, the second time 30 days later, or 6 weeks after admission. The results obtained and tabulated are as follows:

Month	Total No. of Found	
	Cases	Active T. B.
February	263	0
Mareh	219	1
April	36	1(?)
May	15	0
June	34	0
July	13	1
August	16	0
	596	3

In looking over this table we find that out of 596 cases examined, only 3 showed unmistakable signs of a recent reactivation of an old tubercu-
losis directly attributable to measles infection. Of the three eases mentioned, one had, after the second examination, suspicious findings—chiefly crepitant rales in the right upper lobe, which persisted after cough, but this chest had cleared up entirely at a third examination, one month later. The second ease mentioned was a frank reactivation, but on looking up his reecords it was found that he had been under observation at the Tubereulosis Clearing Station on suspic-
ious findings a week prior to his admittance into the base hospital for measles. It seemed to us

*"Tuberculosis Clearing Station" was established at Camp Grant, Ill., in February, 1918, for the purpose of tuberculosis-control in this cantonment, by Clarence L. Wheaton, Major, M. C., U. S. A.

hardly fair to consider measles the cause of this reactivation.

In conclusion, of 596 cases examined, only one was a frank example of an active pulmonary tuberculosis resulting directly from a measles infection. These figures, plus similar ones gathered from other cantonments, seem to vitiate, then, another favorite theory, that measles are a predisposing factor towards pulmonary tuberculosis.

FOURTEEN POINTS CONCERNING OPHTHALMIA NEONATORUM.*

FRANK ALLPORT, M. D.,
CHICAGO.

In participating in this symposium concerning ophthalmia neonatorum, I shall not even attempt, in the brief time allotted to me, to do more than refer to certain essential features connected with the subject.

Like President Wilson, I have endeavored to formulate fourteen points that I consider especially important in connection with the subject which is under consideration this evening.

First. Ophthalmia neonatorum is responsible for about 20 per cent of the blind in the United States and for about 25 per cent of the inmates of blind asylums.

Second. It costs about \$30 a year to educate an ordinary child and about \$400 a year to educate and care for a blind child. This does not take into consideration the many financial and sociological side-lights to blindness and the personal and state misfortunes incident to blindness and unproductive citizenship.

Third. There are about fifty blind schools in the United States, costing about \$2,000,000 a year to maintain.

Fourth. Ophthalmia neonatorum costs the United States about \$7,000,000 per annum in actual money.

Fifth. Next to optic nerve atrophy, ophthalmia neonatorum is the most prolific cause of blindness in the United States.

Sixth. The Credé treatment for all new-born children would almost entirely eliminate ophthalmia neonatorum and its dreadful consequences from the world.

Seventh. The use of this evidently necessary treatment is by no means universal, and its omis-

sion is not confined to midwives. Some reputable physicians use it invariably; others never use it; still others use it when conditions are suspicious. In order to accomplish its purpose, the use of this treatment should be invariable. It should become recognized as an integral part of a woman's confinement, and as a reliable provision against blindness. It should be understood that gonorrhea is not the only condition that will produce this disease, but that it may occur from other and non-disgraceful causes.

Eighth. Midwives are a financial and sociological necessity. Fully one-half the confinements are attended by midwives. If it were not for midwives, most of these cases would be merely looked after by friends and relatives. Midwives should be educated, examined, licensed and inspected, and should always call in medical assistance in complicated cases. The first school of this kind was established in 1913 at Bellevue Hospital, New York City, and has abundantly proven its usefulness. Intelligent women are receiving these instructions, and many graduated nurses have undertaken midwifery as a profession.

Ninth. Births should be compulsorily reported within a few hours. The ocular condition should be reported, and the physician should state whether or not he has used the prophylactic treatment. The method of using the prophylactic, and the state law (if any exists) should be printed on the report blank. Immediate action should follow reporting. By action is meant medical attendance (hospital preferred), nursing, etc.

Tenth. Suitable laws should be passed in each state providing for the invariable use of Credé prophylaxis in all newly-born children, and proper penalties should be imposed for the non-observance of such instruction. Such laws should be not only enacted but observed. A few punishments for disobedience would result in the universal state observance of the law.

Laws in themselves are not sufficient; they must be obeyed. One of the best means of insuring such obedience is to create intelligence on this subject by propaganda, publicity, etc. Every legitimate method of educating and enlightening the people, the midwives and the doctors should be encouraged. If this is done, the proper laws are passed and obedience enforced, it will not be long before the Credé idea of preventing much

*Read before the joint meeting of the Chicago Ophthalmological and Chicago Medical Society, Dec. 18, 1918.

needless blindness will become a matter of course and its use demanded by expectant mothers and their families.

Eleventh. While not prophesying as to what the future may produce in the way of prophylaxis, it is reasonably certain that at present there is no remedy that can take the place of nitrate of silver. Argyrol, protargol, collargol and many other remedies have been proposed, enthusiastically endorsed, widely used and gradually abandoned. Nitrate of silver alone has stood the test of time. The ideal remedy is, of course, one that—

1. Reliably destroys the micro-organisms.
2. Does not injure the eye.
3. Does not produce prolonged redness.
4. Does not cause pain.
5. Does not deteriorate by time, light or exposure.
6. Can be freely used.

Unfortunately, nitrate of silver only responds to one of these qualifications, viz., it reliably destroys the micro-organisms. It does, however, sometimes injure the epithelium, produce prolonged redness, cause pain, deteriorate by time, light and exposure, and should not be freely used. There is, therefore, room for improvement, and it is hoped that a perfect drug will be found; but until then, nitrate of silver should be the standard remedy, for it can almost invariably be depended on to destroy the micro-organisms, and, after all, that is the main thing to be considered. Besides this, all the objections to its use are really trifling and can be easily overcome. Cases of injuries to the epithelium are extremely rare; continued redness is not often seen; the pain is slight and temporary; deterioration can be overcome by only using absolutely fresh solutions, and it is easy to only use one or two drops. Many careful observers believe that the 2 per cent solution of Credé is unnecessarily strong and severe and that just as good results will be attained by a 1 per cent solution, thus reducing by one-half the objections to its use. It is quite possible that this view is correct. It should not be forgotten, however that cases where a 2 per cent solution have produced really objectionable results are extremely rare, and might have been easily due to drug deterioration rather than to drug strength. The cloudiness in a deteriorating silver solution is due to the liberation of free nitric acid, which

is, of course, very irritating to the delicate ocular epithelium.

In order to provide free and reliable silver solutions some states and cities prepare and distribute fresh and carefully compounded solutions to doctors and midwives on application. For instance, New York State distributed last year nearly 20,000 outfits of a 1 per cent solution of silver. Circulars in English, Italian and Polish were freely distributed through about 1,600 health officers to doctors and midwives. It cost about \$5,000. Think of the economy of this measure, to say nothing of its benefits to individuals, families, municipalities and mankind in general. Free distribution does not imply parsimoniousness on the part of doctors and midwives. It is done to provide reliable aseptic solutions to prevent accidents in writing prescriptions and in druggists' work, to insure against drug deterioration, etc.

Twelfth. One almost insurmountable difficulty in the way of proper treatment of ophthalmia neonatorum is the paucity of resources in combating the disease. This disease apparently has no friends. Nobody wants it around. A small hospital should be established in all large cities for the prompt reception of such cases. Or it should be clearly understood by health officers, doctors, midwives, visiting nurses, etc., that certain hospitals will receive such patients, in special wards, at any time, day or night, and undertake to provide expert medical attendance, care, day and night nursing, etc. Mothers who are nursing their babies should either stay with them or come at stated intervals to continue the nursing. In no other way can this disease be successfully handled. Its progress is swift and terrible. A few hours may mean permanent blindness. There is no time to wonder what can be done. This should all be understood beforehand and prompt action immediately taken. Private homes, especially of the squalid variety, are no places for the treatment of this disease.

Thirteenth. Health departments in the larger cities should employ an experienced eye nurse to search out and follow up cases of ophthalmia neonatorum and to see that immediate action is taken when cases are found.

Fourteenth. I believe that great benefit can be accomplished by the free and frequent distribution of brief and pointed pamphlets, printed in several languages, by some central organiza-

tion, such as the National Committee for the Prevention of Blindness. Such "leaflets" should be sent to different organizations in the different states, such as boards of health, dispensaries, etc., to be freely and frequently distributed to doctors, midwives, expectant mothers, etc. I am here submitting a sample of such a "leaflet."

WHAT TO DO BEFORE THE BABY IS BORN.

1. The care of a child's eyes begins BEFORE it is born.

2. The mother's parts, through which the child passes at birth, should be washed several times a day with soap and water, for about one week before the baby is born.

3. If a discharge comes from these parts, the mother should at once consult a good doctor, at his office or free dispensary, for this discharge, if not stopped, will be a *terrible poison* to the baby's eye.

4. This discharge may be caused by "The Bad Disease," or it may not.

In either case it should be stopped, *or a blind baby may be the result.*

5. If for any reason a doctor is not consulted, the mother should not only keep her parts clean, with soap and water, but she should get a fountain syringe and syringe out her parts, several times a day, with warm, boiled, soap and water.

6. The mother should be careful to keep her hands clean and to keep her hands away from her eyes, or she may get some of the poison in her own eyes, and cause blindness.

7. All cloths, etc., used by her in cleaning her parts *should be burned*, as they may be full of poison. It is better to get quantities of cheap cheese cloth and then burn it.

8. If the mother has a discharge coming from her parts, she should keep away from the other people in the family as much as possible, for she may poison them and cause the same disease, and possibly blindness.

9. If the mother has a discharge, she should try and use a separate water closet or vessel, and keep everything perfectly clean with soap and water cleansings.

10. *It would be better for babies to be born in hospitals*, where everything is convenient and clean, and where the mother may be sure of a good doctor and nurse, and where, if mothers are too poor to pay out money, they can be cared for free.

11. If the mother does not go to a hospital she should, if possible, call in a good doctor, as midwives are unsafe.

12. If the mother is poor, she should not forget to call a visiting nurse. *They know their business and can tell the mother what to do.*

WHAT TO DO AFTER THE BABY IS BORN.

1. As soon as the head is born the mouth should be swabbed out with a cloth upon a finger, the face should be washed with clean water, and the lids should be especially cleaned.

2. After the child is separated from the mother, the face should be again washed, *without soap*, giving especial attention to the lids.

3. The eyes should now be washed out with a Solution of Boracic Acid. To do this, take a pint of clean water that has been boiled and allowed to cool. Then put two teaspoonfuls of Boracic Acid in the water and stir it up with a clean spoon. Then open the baby's eyes and Flush them out with a few teaspoonfuls of this solution.

4. The lids should now be opened and two or three drops of a 2 or 1 per cent. Solution of Nitrate of Silver should be carefully dropped into the eyes.

Be sure the medicine gets into the eyes.

This should be done *always*, even in cases where there is no reason to suspect disease.

It almost surely prevents dangerous "baby's sore eyes!"

5. The drops usually make the eyes a little red for a few hours, but this does no harm.

If it is not done, a blind baby may be the result!

6. Mothers should *be sure* that this is done, *even* if the doctor does not think it necessary.

7. Mothers should not think that breast milk, or tea leaves, or poultices, or *anything else*, will serve the purpose. Cleanliness and the Nitrate of Silver Solution are the only things that will do; *especially the Silver solution.*

8. If the baby's eyes get red a few days after birth, *the baby should be taken to a good doctor at once.* Or, better still, take the baby to a good eye doctor, *at once.*

Do not wait, thinking it is "just a little cold," and hoping the eyes will be better in a day or two.

10. Do not listen to what the neighbors say. *Consult a doctor at once. Delay may mean blindness to the baby.*

11. If a newly born baby has "Sore eyes," the best place for it is *in a good hospital*, where it can be properly cared for. Such cases require careful treatment *every half hour day and night.* If the child is not taken to a hospital, however, *two* paid nurses, or *two* visiting nurses, should take care of the baby, day and night.

All this could have been prevented if the Silver Solution had been dropped into the eyes when the baby was born!

12. All cloths, cotton, etc., used around the baby's eyes should be *instantly burned.* Every one touching or treating the baby should keep perfectly clean. *The hands should always be washed immediately after touching the baby.* People coming in contact with a baby having "Sore Eyes" should, if possible, be kept in a *separate room*, away from the rest of the family.

On the first or outside page will be the following printed matter:

BABIES' SORE EYES AND HOW TO PREVENT THEM.

Cleanliness and two drops of the following formula would have prevented this child from becoming blind. (Picture of a blind child.)

Nitrate of Silver, 8 grains, or 4 grains.

Distilled water, 1 ounce.

Put two drops in the baby's eyes immediately after birth. The face and lids should first be cleaned with pure warm water.

This formula can be obtained at any drug store, and must be used on every baby.

7 W. Madison St.

SURGERY OF THE GALL-BLADDER AND BILE PASSAGES.

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OAK PARK, ILL.

The advancement in surgery of the gall-bladder is fraught with great interest. The first successful cholecystotomy was done by Bobbs, of Indianapolis, in 1867. In 1878 Kocher did a two-stage operation of draining the gall-bladder, but it was not until 1882, after Langenbuch did a successful cholecystectomy, that gall-bladder surgery received much attention.

Symptoms. In a series of 452 cases studied by Bodestab, 311 had stones, and 141 cholecystitis without stones. Tenderness, the most constant symptom, was present in over 85 per cent of the cases with stones and 93 per cent of the cases without stones. Vomiting occurred in 80 per cent of the cases of cholelithiasis and 45.5 per cent of the cases of cholecystitis without stones. Belching was present in 79.5 per cent of cases with stones and 70.9 per cent of cases without stones. Dyspnea during the attack occurred in 70.8 per cent of the former group and in 39.7 per cent of the latter group. The sensation of impending death is a very frequent sign. Radiating pain occurred in 71 per cent of cases with stones and 39.7 per cent of cases without stones. Reflex symptoms of digestive disturbance were present in 29 per cent of the first group and 41.8 per cent of the second group were characterized by no definite food relation. Twenty-three per cent of the stone cases and 8 per cent of cases without stones gave a history of jaundice. Many of the cases had bile in the urine the first 24 hours after an attack.

Stone or stones may require several months to form, and during the antecedent period of gastrointestinal catarrh, certain symptoms may exist, such as constipation, flatulence, loss of appetite, migraine, uneasy sensations in the epigastrium or right hypochondrium, sallowness of the skin, slight yellowishness of the conjunctiva, scantiness of urine, which excretion is saturated with uric acid and may after a time contain a

little bile. In many instances the symptoms which stones cause are thought to be due to disease of the stomach, as indigestion, flatulence, pain after eating, pyloric spasm, etc. The symptoms may not bear any relation to the size or number of stones. In fact, gall-stones give rise to active symptoms only when infection occurs, or when the ducts become occluded and cease to drain, or when the stone starts to pass. In persistent jaundice due to gall-stones the gall-bladder is seldom enlarged.

In acute cholecystitis the attacks usually begin with biliary colic, which may be mild or severe. In many cases of cholecystitis the pain is not very severe at first and is felt in the epigastrium or in the right hypochondrium. Sometimes referred pain is felt in the right shoulder, under the scapula, or in the right iliac fossa. If the gall-bladder lies low in the abdomen, it may be confused with appendicitis. Nausea and vomiting usually occur, but may be entirely absent. Muscular rigidity and tenderness over the site of the gall-bladder are constant and very valuable signs. The gall-bladder becomes enlarged and usually can be outlined by percussion, and if rigidity and tenderness are not very great, it may be palpable as a smooth, rounded tumor beneath the costal margin continuous with the liver dullness and moving in respiration unless fixed by adhesions from previous disease. There usually is fever, but the temperature is seldom very high. There is polynuclear leukocytosis. If there is much constitutional reaction, and if the elevation of temperature continues for several days and is high, empyema or threatening gangrene should be suspected. Perforation into the free peritoneal cavity is rare.

Kehr found jaundice absent in 25 per cent of his common duct cases. Bruning, in 273 cases, reports that in 8 per cent there was no jaundice and 22 or 29 of the common duct cases in which no calculi were found had icterus. Van Buren, in 33 common duct cases, found icterus absent in 6.

Diagnosis. A carefully obtained history, concise, clear and accurate, has been of greater aid in the diagnosis in gall-bladder disease than any other diagnostic data. It is more perplexing to make a diagnosis in chronic cholecystitis without stones, when the signs and symptoms are less prominent; even when the abdomen is opened, the gall-bladder, with much affected mucous mem-

brane, may show little or no change in the external appearance and condition of the outer coats. In a large number of cases of cholelithiasis there is an increase of the cholesterin content of the serum, which is of diagnostic importance and which is found in other conditions frequently mistaken for this disease.

Cholesterin is supposed to pass from the intestine into the circulation, becoming accumulated in the liver, suprarenals, and so on, and is afterwards eliminated by the biliary tract and intestine. Material for the formation of solitary cholesterin stone crystallizes out of the sterile bile. The process is augmented by the scaling off of the epithelial cells of the gall-bladder. By accurate investigations of gall-bladder extirpated by operations or found at autopsy, it has been found that when a single cholesterin stone was present, every sign of inflammation of the gall-bladder was missing, and only the evidences of gall-bladder stagnation were found.

In making a diagnosis, all data should be correlated and, if necessary, an analysis of the other organs should be made so as to rule out conditions presenting a similar symptomatology.

Acute cholecystitis must be distinguished from appendicitis, gastric or duodenal perforation, intestinal obstruction, and acute pancreatitis. In most cases a correct diagnosis is easy, owing to the localization of the signs and symptoms to the gall-bladder region, and the recognition of the enlarged gall-bladder.

Einhorn has diagnosed probable cholecystitis by indirect examination of the bile in 40 cases and says that in the majority of cases in which turbid bile is found in the duodenum in the fasting condition, cholecystitis with gall-stones exists. Most surgeons are agreed that the history is not only the largest element in making the diagnosis, but is also of greater importance in deciding the question of whether to remove or retain the gall-bladder. If the history should show persistent symptoms, indicating chronic infection, the gall-bladder had better be removed. On the other hand, it takes the highest and most refined surgical judgment to decide, at times, which will give the most ultimate benefit to the patient, the retention or removal of the gall-bladder. In addition to a carefully obtained history, an important point is an attempt to exclude by a process of elimination conditions that simulate gross lesions of the bile tract.

Another important point is the physical examination of the patient along with laboratory tests and x-ray findings.

Surgical Treatment. The writer wishes to direct his remarks to a discussion of when to operate upon one class of patients, the acute cases of bile passage disease that are septic and jaundiced. Patients who are both septic and jaundiced furnish 97 per cent of the mortality of bile passage surgery. A gall-stone patient who is septic, but who has no jaundice, does not present a difficult problem. A gall-stone patient who is jaundiced, but who has no sepsis, is not a grave risk; but the patient who is at the same time both septic and jaundiced must be handled with judgment and skill if he recovers.

These cases should be divided into two classes. In the first class the jaundice occurs early in the attack and is followed by sepsis. These patients should not be operated on during the acute stage.

The second class become jaundiced only after the attack has been going on for several days and sepsis is well established. These patients should be operated on as early as possible. This classification, which is so readily recognized by the symptomatology, is based on the pathology of obstruction of the common duct. When the jaundice precedes the sepsis the common duct is obstructed by a foreign body within its lumen. The sepsis comes on after the jaundice is well marked. In these cases there is no pathology outside of the duct to interfere with its becoming dilated by the back pressure, which rapidly increases as the result of the obstruction and sepsis. When the duct dilates the obstruction is somewhat relieved and the patient improves. Operation should be delayed in this class of patients. When the sepsis has preceded the jaundice the common duct is not obstructed by a foreign body within its lumen, but by pressure from inflammatory swelling outside the duct—a large stone impacted in the cystic duct. A pericholecystitis and enlarged lymph glands are commonly the cause of pressure and occlusion of the common duct in these cases. When such a pathology exists, the duct cannot dilate to relieve the obstruction. Delay in these cases is useless and dangerous, and operation should be done as soon as possible. There is little of value in the medical literature that bears directly on this subject. It is generally agreed that sepsis means infection and jaundice, and that gall-stone disease means

obstruction of the common duct. In actual practice, obstruction of the common duct with sepsis occurs as frequently from pressure outside the duct as it does from foreign bodies within its lumen. Kehr advises a waiting policy in obstructive cases with sepsis. Deaver believes that waiting in such cases is good for the surgeon but bad for the patient, and he advises operation without delay. They are both right, part of the time. In septic obstruction of the common duct the advice of Kehr to wait should be followed if the jaundice has preceded the sepsis, but if the jaundice has followed the sepsis the advice of Deaver should be followed and operation done at once.

In operating, unless all the bile tract can be explored, there is great risk of a small stone, or even many stones, being left behind. Even very firm adhesions will yield to time, patience and dexterity. No operation need ever be abandoned because the adhesions are supposed to present an insuperable obstacle. When all is quite clear, then the gall-bladder, with the liver, is seized in the hand, covered with gauze and gently dragged downwards from under the shelter of the ribs. If this can be effected, it will be found easy to rotate the liver, turning the gall-bladder upwards, so that what was its under surface now faces upwards and forwards. By this maneuver the cystic and common ducts are brought almost into a straight line, and the common duct, which at first seemed so deeply hidden in the abdomen, can now be brought forward until it lies almost or actually on a level with the skin. In this way the ducts can be most thoroughly explored, and the surgeon may satisfy himself of the certainty of being able to remove all the stones.

With reference to cholecystotomy, it is demanded where there are the acute infective conditions for which instant relief is necessary and in patients whose powers of withstanding the shock of any detailed operative procedure are small. One point which requires further investigation is as to the frequency and character of the after results of cholecystotomy. It is desirable that we should know of the frequency of the recurrence of gall-stones, and this should be distinguished from the recurrence which is the result of incomplete removal of stones, and of the symptoms that ensue when adhesions have formed to a chronically inflamed gall-bladder, even after all stones have been removed. Of the

former there is some evidence forthcoming, although no doubt it is not all available, and of the latter there is some evidence, and one noted surgeon has said post-operative adhesions to the gall-bladder embitter the liver of many of our patients.

It is the writer's belief that cholecystectomy should be the operation of choice.

The removal of the gall-bladder does away with the need for drainage. It renders less likely the presence of the inflammatory consequences. If the need for drainage is absolute, it is possible to drain the ducts after the gall-bladder is removed. The pressure of a stone in the common duct does not debar one from removing the gall-bladder.

A stone may be lodged in the common duct in any part of its course. If it is found in the first portion of the common duct, or if it is found in the second part of the common duct and can be milked upwards into the first part of the duct, then a supraduodenal choledochotomy will be necessary. When a stone is in the second part of the common duct or in the ampulla of Vater and cannot be worked upwards into the first part of the duct, then a duodeno-choledochotomy will be found necessary.

In operating for obstruction of the common duct, access to the duct may be obtained in three directions: Above the duodenum by supraduodenal choledochotomy; behind the duodenum by retroduodenal choledochotomy, and through the duodenum by duodeno-choledochotomy. Choleochotomy performed upon the first portion of the common duct is the simplest operation. All steps of the operation up to the suture of the abdominal wound are simplified by placing a large sand bag or air cushion under the patient's back, behind the liver.

In reviewing the literature one cannot help being impressed by the fact that cholecystectomy is being done much more frequently today than it was several years ago, but a careful study of the individual case should be the guide of the surgeon in determining what particular operation to do.

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A CASE OF POISONING BY CORROSIVE SUBLIMATE.

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The chief interest of this report is the remarkably short fatal period.

A few minutes after 8 o'clock on November 29th I was somewhat startled by having a man rush wildly into my office with the information that a woman had taken poison in a rooming house about a half block down the street. I started immediately, picking up my hat and bag from a chair as I passed out of the office. On reaching the apartment I found the patient sitting on the toilet in the bathroom, her head braced against the wainscoting on the side and moaning inarticulately. On the tile floor in front of her was the vomitus—a considerable quantity of bluish, foamy mucus, no blood. Her lips were cyanosed; the eyes were closed and resisted slightly as I opened them. The pupils were large, but I did not at this time try them for reaction to light. The radial pulse was irregular and weak—fluttery—and the respirations shallow and apparently incomplete. As I took her pulse there was a slight tremor of the extremity. I immediately gave her one-tenth grain apomorphine and prepared for another, using hot tap water. I ordered the whites of several eggs prepared and that the remainder of the poison be brought to me. As I turned back from the washstand, where I had placed the syringe, she was just passing into a convulsion. We then removed her to her room and placed her in bed.

At this time the radial pulse had disappeared, so I gave her a thirtieth of strychnine, followed immediately by twenty-five minims of whiskey per hypo. Not being able to feel an apex beat, I used the stethoscope and found that she was dead. This was at 8:20, and on questioning the family I learned that following a family spat she had rushed into the bathroom about 8 o'clock, emerging a few minutes later trying to vomit. They led her to her room, but she expressed a desire to use the toilet, so they led her back where we found her. We found the rest of the poison on a chiffonier in the bathroom. It consisted of blue liquid, a heavy blue sediment having precipitated out and was deposited in the bottom of the glass. The coroner's chemist reported, "A heavy and corrosive metal having all characteristics of bichloride of mercury."

The literature on poisoning by corrosive sublimate is quite voluminous, but the shortest fatal period I have been able to find was thirty minutes. In this particular case it seems that the tenesmus and urging to stool came immediately after the usual burning sensation of the mouth and esophagus and then, in quick succession, the tremors and muscular contractions. The death in this case bore a distinct likeness to the phenomena of shock.

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LAST WORD IN TREATMENT OF PNEUMONIA.*

ALVAH LEWIS SAWYER, M. D.,
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A. General Management. The general care of the patient is so very important that I wish to give briefly a review of the general line of procedure.

The patient should be placed in a well-ventilated room or in the open air, if possible. The bed should be equipped with a firm, non-sagging mattress. Absolute quiet should be maintained throughout the sickness. In hospital cases the various types (I-II-III-IV) should be carefully separated to avoid cross-contamination. This would throw an additional burden upon the patient's resistance, already heavily taxed.

The alimentary tract should be thoroughly cleared by means of calomel, given in small divided doses, followed by a saline.

*Read before the Aux Plaines Branch of the Chicago Medical Society, November 22, 1918.

The mouth should be cleansed thoroughly morning and night, an excellent mouth wash for this purpose being the ordinary liquoris antisepticus.

Control of the fever should be accomplished by means of bathing with either alcohol or warm water. The frequency of both should be determined by height of temperature. Avoid the use of antipyretic drugs in this connection.

Pain must be relieved as soon as possible by hot or cold applications. These failing, no delay should occur in administering morphin sulphate. One-tenth to one-sixth grain has, in the hands of the writer, proved to be sufficient to give relief for about four hours.

Cough, of the dry, non-productive variety, is lessened if a cough mixture containing a narcotic and some expectorant is given every two or three hours.

R

Codeinae sulphatis, gr. viii.
Ammonii chloridi, gr. xxx.
Syrupi tulutani, qs. ad. 3 iii.
Misce.

Signa: Teaspoonful every two to three hours.

Toxemia is best combated by hypodermoclysis of a saline infusion or by rectal irrigation with normal salt solution.

The heart must be carefully watched from the beginning and proper medication administered as soon as indicated. Rules for beginning cardiac stimulation the writer would classify as follows:

1st. In aged and alcoholics and patients with a pre-existing myocardial disease, start stimulants at once.

2nd. In young, previously healthy individuals, do not begin stimulants until signs of heart strain appear, which is generally about the fourth day.

Heart stimulants should be selected with some care. Strychnin in most cases should be first selected. The dose should be from 1-60 to 1-30 grain every three to six hours. If greater stimulation is needed, use tincture of strophanthus in doses of one and a half drops every four hours. In obstinate, dilated right ventricle, resort to digitalis. The writer finds digitalis in hypodermic doses of 1-60 to 1-20 grain, in addition to other stimulants, very satisfactory. If extreme dilatation persists, with high blood pressure, venesection is indicated. In the condition

of low blood pressure the use of epinephrin in one to fifteen-drop doses is generally effective.

The diet should be non-putrefactive and should include salts needed by the body, especially the calcium salts always deficient in pneumonia. The food should furnish a maximum amount of nourishment with a minimum amount of disturbance to the alimentary tract. Lack of care in this respect may lead to such grave complications as autointoxication, vasomotor paralysis, nervous disturbance of the heart through reflexes and mechanical disturbance due to distention. The physician wishing to avoid trouble for himself and patient will spare no watchfulness and care of the diet. The menu for acute stage for a period of twenty-four hours should be as follows:

2 pints of milk.
2-3 pints of barley water.
7 oz. syrup of glucose.
5 drams of table salt.
1 dram of glycerophosphate of calcium.

The acute stage past, these additions are permissible: broths, raw eggs, jellies, cocoa, coffee and a few crackers. Water is to be given whenever the patient desires it, except in right heart dilatation when fluids must be more carefully restricted.

B. Special Therapy. Although there are many lines of treatment, advocated by as many authors, time has been a hard master and few of them survive. However, I wish to put emphasis upon the use of camphorated oil, given in overwhelming doses, subcutaneously. If given early in the disease, it has the tendency to abort the attack, the patient often reaching normal in three to four days except that the exudate remains but is absorbed later on.

The administration of camphor in oil should begin as soon as possible after the initial chill. Inject 12 c.c. of a 20 per cent. solution every twelve hours until three to four doses have been given. For children the dose should be 5 c. c. for 50 pounds of body weight. The injection can be given over abdomen or on outer side of thigh, but care must be taken to get needle under the adipose tissue and to give it very slowly.

C. Serum Therapy. The general use of serums in pneumonia has been most disappointing. They have been in most cases the shot-gun variety and therein do we find their weakness. If a serum is to be effective it must be absolutely

homologous with the invading organism. The importance, therefore, of a careful bacteriological diagnosis is at once apparent if the serum treatment is to be followed with any hope of success. The importance of such a diagnosis leads me to give at this point the laboratory technique for the determination of the type of the pneumococci infection, namely, whether it is Type I, II, III or IV.

PROCEDURE.

1. Collect sputum of patient in a sterile dish or bottle and take to laboratory at once.

2. Take small portion of sputum and wash three or four times in sterile salt solution. Next make an emulsion of this sputum and sterile broth or salt solution.

3. Inject emulsion into the peritoneal cavity of a mouse, where the pneumococci quickly outgrow all other organisms. Kill the mouse as soon as it appears sick, which may be anywhere from five to twenty hours, but generally about seven hours.

4. Remove the exudate from the peritoneal cavity and make a microscopic agglutination test against the immune serum of each of the four recognized types. This will determine for the physician what serum to use.

Up to the present time, however, only one of these is efficient in the treatment of pneumonia, that is serum for Type I.

D. Prophylactic Vaccination. In vaccination seems to rest the greatest hope in our fight against this dread disease. It has been proved out and is found to be successful for types I, II and III.

I wish to quote from the Acting Surgeon General's instructions to all surgeons in our army, under date of October 25, 1918, as follows:

1. The value of vaccination against certain of the more important organisms giving rise to pneumonia may be considered as established by the experiments of Lister in South Africa, and by the more recent results of prophylactic vaccination in our own Army.

2. In South Africa during the past four years, Lister has given prophylactic vaccination against the three most important types of pneumococcus there prevalent. In this period not a single case of pneumonia due to a pneumococcus of the types used in the vaccine has occurred among the vaccinated individuals, each of whom has, as a rule, been under observation for about nine months following vaccination.

3. In our own Army vaccination was given last winter as a prophylactic measure to half of one Division, using a vaccine containing pneumococcus types I, II and III. During the ten weeks from the

period of vaccination until the troops went overseas, pneumonia due to these three types of pneumococcus did not occur at all among the vaccinated troops; whereas, among the unvaccinated it occurred a trifle more frequently than in the period before vaccination.

From this glowing report it seems almost certain that the physician can look into the near future with more confidence in meeting the foe pneumonia, than he has had in all the ages past. It is easy to predict that it is but a question of time ere we will be vaccinating against pneumonia as we now vaccinate against small-pox.

4052 W. Madison St.

A CASE OF HEMORRHAGIC NEPHRITIS COMPLICATING MUMPS.

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As mumps is rarely complicated with a kidney lesion it might be interesting to report the following case.

The patient, a girl six years old, had, according to the mother, a swelling of the right jaw. Previous history negative, particularly as to scarlet fever. Further inquiry divulged that there had been some malaise and temperature.

Examination showed a slight enlargement of the right parotid which was not very painful; there was no difficulty in opening the mouth; temperature by mouth was 102.6; diagnosis, a mild attack of mumps.

I was recalled to see this case a week later and found the patient in bed where she had been for three days and disinclined to get up. Examination showed the parotid still a little enlarged. In spite of the absence of pain anywhere, the child looked ill and there was a slight puffiness about the eyes; there was no temperature; pulse 120 and irregular; examination of the chest disclosed nothing; bowels had moved well. The mother was asked to collect a quantity of urine and send same to the office which she did. Examination of urine showed a large amount of albumin, no sugar, and a sediment filled with large, coarsely granular casts and blood. For the next three days the total quantity of urine passed in twenty-four hours averaged about four ounces and was red and thick. During this time the temperature ranged from 99 to 101.4; pulse was irregular. There were no other symptoms with the exception of a marked prostration and tendency to sleep.

The child was put on a restricted diet, hot saline injections were given, and also digitalis. This treatment began to bring about a slight increase in the urine excreted and in eight days' time a normal quantity was passed. During this time the edema gradually extended to the face, abdomen, and feet. As the urine increased each day the pathological findings became correspondingly less and the child was allowed to sit up a little until she was up most of the time. The urine had cleared up, but the child was very weak.

Ten days later the mother again noticed that the urine was red and brought a specimen to the office. Examination showed much blood, but no casts; the general condition of the child was good. It was my opinion that the hemorrhage was most likely due to the anemic condition of the patient and an examination of the blood showed only 50 per cent hemoglobin. The child was given extract of red bone marrow and sodium cacodylate which resulted in a total disappearance of the blood. At the present writing the child is apparently normal.

25 E. Washington St.

THE EFFECT OF STRENUOUS OCCUPATIONS ON THE BLOOD AND CARDIOVASCULAR SYSTEM.*

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At the dawn of history, in the days when the medical men first began to learn the secrets of disease, it was already known that certain occupations cause certain diseases.

In the days of Hippocrates and Galen, the question of the relation of longevity and health to certain occupations was discussed, studied and recorded. These and many other writers refer in their writings to carriers of burdens, miners, sailors and chemists in their discussions of diseases caused by occupations.

There is a vast amount of accumulated knowledge treating of industrial diseases for the comparatively short time since this subject has been taken up as a special study. There are many ramifications and separate branches to this great subject; but the limited time and space accorded such a paper will not permit me even to touch on

many important factors. Therefore, I will limit myself only to the blood and circulatory system and show what effect certain occupations have on them.

I had the opportunity to examine a great number of workmen of different trades for a certain fraternal and insurance organization. I could not help notice that the more violent the work and the more strenuous the labor the oftener I have found hemic and other murmurs, as well as many other symptoms of cardiac disturbance. This made me look more carefully into this matter and record the different trades as to their relation to cardiac troubles. Out of fifty-five tailors, examined, I have found only two cases where I have noticed a marked cardiac disturbance, while quite a few of them were showing symptoms of tuberculosis and most of them had the typical physical disturbances of their trade, such as—chronic bronchitis, emphysema, catarrhal conditions of the nasopharynx, marked nervousness, defective vision, bad teeth, pyorrhea, habitual constipation and digestive disturbances. All these conditions are typical of the tailoring industry and are invariably caused by insufficient ventilation, faulty postures, constant sitting positions and errors in dietetics. To these we may add the ever present "speeding up" as most of the employes are piece workers. Of the other trades examined, out of eighteen pressers, four were showing the typical symptoms of cardiac disturbances, all the pressers using fifteen to twenty-four-pound irons daily for eight to ten hours. The physical strain being very much in evidence in these cases, their cardiac conditions were the result of this strain. Out of twenty carpenters-building trades, five had murmurs. Out of twelve plumbers three had symptoms of cardiac disturbances and out of nine blacksmiths and iron workers, three had very marked symptoms of cardiac disturbances. While all the cases and figures given are by no means conclusive, nevertheless they help to prove that the more violent the occupation, the more frequently we find cardiac disturbances.

The etiological factors which will be considered are only those which are invariably connected with various industries. Syphilis and alcohol, although a great etiological factor in the diseases of many workmen, will not be considered because they are in no way necessarily connected with occupational diseases. Speaking in general, the

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etiological factors affecting the blood and the circulatory system are:

Industrial chemical poisons,

Exposure to physical forces,

Defective hygienic conditions,

under which people labor in many industries. And most important of all are those that act mechanically, such as *strain*.

As the blood is so very much in evidence at present in medico-scientific circles that no matter what the condition or pathology of the patient may be, the blood is the first source to which we look for enlightenment to unravel the mysteries of disease. To a certain extent the blood has become an open book from which we read about diseases and become enlightened. In this connection I will just mention a few industrial diseases which have a direct effect upon the blood proper.

First, Hemoglobinemia. The presence of free hemoglobin in the blood is caused by a hemolysis produced by the coming in close contact with arseniureted and carbureted hydrogen. This usually occurs on ships where ferrosilicon comes in contact with water. A milder condition of this kind causes a typical secondary anemia; but in the more severe conditions death is the result of hemolysis and tissue suffocation.

Second, Methemoglobinemia is a condition found in workers who come in contact with such industrial poisons as benzine, nitro-benzol, nitrous gases, anilin and many other dyestuffs.

Third, Sulphemoglobinemia is caused by the action of sulphureted hydrogen on the blood. This is produced by inhaling the air charged with sulphureted hydrogen and is usually rapidly fatal. In the milder cases a cyanosis of the skin and mucous membranes develops with constant headaches and gastro-intestinal disturbances and marked muscular weakness.

Fourth, Cynamethemoglobinemia is caused by the fumes of hydrocyanic acid and cyanides. The fumes act upon the hemoglobin and directly upon the tissues, causing an inhibition of oxygen absorption. This condition is rapidly fatal—dispnea and cardiac failure are the result. A chronic poisoning is caused when workers absorb small quantities of the vapor. The symptoms are similar to those caused by other gas poisons. We also have lead, mercury, phosphorus, chlorine and bromin poisonings with similar detrimental results.

Secondary anemias, acute and chronic, are very well known to be caused by the gas poisons mentioned, as well as by many other poisons used in the arts and in many other industries. I am not going to describe the condition of the blood in these cases. I want only to emphasize the fact that these industrial diseases are preventable.

To resume the etiological factors it may here also be mentioned that insanitary conditions in most of the industries, such as frequent and sudden changes in temperature, foul air, poor lighting, exposure to hot air and long hours of work, very often produce acute and chronic secondary anemias.

Cardiac Over-Strain. While most of the cases of cardiac failure are due to some organic trouble, it is an established fact that a great many cases which are taken for organic cardiac trouble of one lesion or another, are nothing but functional and due to overstrain. This results in a marked disturbance of the circulation.

As a disease due to occupation, it is most frequently found in porters, miners, blacksmiths, prize-fighters, wrestlers and soldiers.

The present European war has clearly demonstrated that thousands of soldiers, when brought to the base hospitals, have been found to have no wounds, but were simply suffering from cardiac over-strain. While some do suffer from cardiac dilatation and perhaps a slightly damaged myocardium, the fact that a prolonged rest overcomes the trouble, goes to prove that the cases are nothing else but cardiac over-strain.

Heart troubles seem to be one of the most serious problems the army surgeon has to deal with. There is a condition known in the English army as "Soldiers' heart," described and well discussed by Sir James Barr. Stadelman in the *Berliner Medizinische Gesellschaft* relates a great number of cases of heart trouble. He states that fifty per cent. of all soldiers are neurasthenics and of this number 50 to 75 per cent. complain of heart trouble, while on careful examination only five per cent. indicate organic heart lesions. This again goes to prove that strenuous occupations, whether civil or military, lead to the same symptoms, which are the result of cardiac over-strain.

Our own soldiers in Mexico went through the same experience. You all read how hundreds of them have dropped at the roadside, while on the march. Evidently, even here young men who are mostly clerks and office workers, not accustomed

to strenuous work, have been overcome by this same cardiac overstrain.

The cardinal symptoms in such cases manifest themselves in a poor cardiac response, the patient being unable to perform the slightest work without exertion and distress, while at rest he feels very comfortable.

There is cardiac pain, a sense of pressure and constriction over the region of the heart, palpitation, headaches, vertigo and buzzing in the ears. The pulse is small, feeble and rapid and quite often irregular. In the more extreme cases dyspnea, edema and other symptoms of cardiac decompensation are present. Cases of tachycardia, bradycardia and palpitation are frequently found among workers employed at chemical industries and no doubt are caused by the gas fumes which act upon the blood as well as upon the heart directly.

When the government was investigating the price of milk in the City of New York during the month of December, 1916, it discovered that most of the milk wagon drivers, after working for about three years, were forced to discontinue their strenuous work on account of cardiac palpitation, due to overstrain. This fact was admitted by the president of one of the leading milk companies of New York. When the investigating board made inquiries as to the reason why the company does not save on the delivery of milk, he made the following statement: "In three years time the average milk wagon driver develops different sicknesses and most of them suffer from cardiac failure. This is due to the fact that the work requires muscular strain."

I suppose that if the method for the delivery of milk be not changed in due time the medical profession will be blessed with another infant in its already great family of diseases, and it will most probably be christened: "Milk wagon drivers' disease."

As muscle is the only asset the laborer has, the more he sells of it the less is left. It is his only commodity and each day his stock of trade is diminishing. At the end he is muscle bankrupt and becomes a fit candidate for Oslerization.

I am not going to take up the medical treatment of the conditions enumerated. As physicians we all know what is to be done medically. I just want to stimulate a tendency to come into closer contact with the workers, to take a hand in the betterment of their physical conditions and

use our influence as men into whose hands God has trusted suffering humanity. It is not cure, but prevention, that we want in such conditions. Cardiac diseases among the working classes are becoming a very alarming factor and it is our duty to prevent them before they become as detrimental to the human race as the great White Plague. In fact, some authorities claim that in the United States cardiac diseases caused by various strenuous occupations are already becoming as dangerous as tuberculosis.

It was not my intention to bring before you something with which you are not familiar. It is my desire merely to emphasize facts which are overlooked by many of us simply because we do not look at it from the proper angle.

A cardiac murmur does by no means spell organic trouble and the case is very far from being hopeless. By having complete control over the patient, by learning of his mode of living and by teaching him how to work with the least amount of risk to his health, we can accomplish a great deal.

It is our sacred duty as physicians, as well as a civic obligation as good citizens, to ameliorate and improve the general working conditions of the laboring classes; as well as to educate the workers of the dangers of these prevailing conditions. We, who come in close and intimate contact with misery, disease and suffering, should be the first to raise our voices against these prevailing conditions, because to doctor does not necessarily mean only to cure, but to teach, as well.

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RUPTURE OF THE SYMPHYSIS.

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Rupture of the symphysis ossium pubis by external traumatism is rare and a report of a case justified. The firmness of the cartilage and fibrocartilaginous bands connecting the ossa pubis and the architecture of the whole pelvis make it plausible that only extreme violence will produce the above injury. Excluding the injuries of the symphysis observed in obstetrics, it is usually a fall from a considerable height upon one side of the buttocks or on the knee, or a crushing injury of the pelvis, the violence acting on opposite sides of the pelvis, which will produce a separation of the symphysis with more or less

injury to the other articulations of the pelvis, the pelvic bones and soft tissue. Mention should be made of the occurrence of this injury on horse back, some claiming that the saddle acts as a wedge, driving the bones apart, others holding muscular action the cause. In each case of separation or luxation of the symphysis of any larger degree an injury of the sacroiliac articulation or its anterior ligaments must occur. The width of the gap between the bones differs and depends on the force and whether all the ligaments were lacerated or not. Quite as large degrees as in obstetrics are not observed in surgery, the normal softening of the tissue during pregnancy being responsible for this.

My patient, a man 30 years old, 5 feet 4 inches tall, 138 lbs., perfectly well, father of two healthy children, no previous sickness, no venereal history, fell while trying to open the upper half of a window and standing on the window sill, out of the window onto the platform of a fire escape one story below. He fell upon his right buttock. Stunned by the fall he recuperated quickly and crawled through the next window into the office building and went home in a taxi, walking from the taxi to his room and climbed up 8 steps assisted by one man. I saw the man two hours later, still dressed, lying in bed and complaining of pain in the back in the region of both sacroiliac joints, radiating into the legs, also of pain in the region of the symphysis, and of pain when trying to use his legs; however, he was able to do so.

A wide gap between the pubic bones, easily admitting the finger, could be felt and the man was sent to the hospital after applying a circular adhesive strap around the pelvis. The next day a large hematoma over the right tuber ossis ischii, bluish discoloration of the skin of the penis and the upper part of the scrotum could be seen. The patient could not urinate and had considerable meteorism and nausea. He complained of pain in the back corresponding with both sacro-iliac articulations and tenesmus. There was a slight elevation of temperature, normal blood count, normal hemoglobin; a rectal examination did not reveal any other injury and the catheterized urine was normal. Before applying a permanent adhesive bandage the patient was taken to the x-ray room, but he complained of such intense pain in the back after removal of the temporary straps, that during the taking of the x-ray picture at

least a tight towel had to be pinned around his pelvis. For this reason the picture does not show the actual width of the separation. An adhesive plaster strap brought the bones into good apposition and after three weeks the man could walk comfortably with no lameness. Meteorism and retention of the urine disappeared after four days.



Fig. 1. This picture does not show the actual width of the separation. On account of severe pain, the pelvis had to be strapped.

The unusual feature in this case is that the man right after the injury was able to walk and climb steps, assisted only by one man, although we find in most cases, observed in obstetrical practice, where rupture of the symphysis occurred without being recognized, that the patients were confined to bed for many weeks.

PATHOLOGY AND TREATMENT OF SEMINAL VESICULITIS AND ACUTE EPIDIDYMITIS.

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The purpose in reading this paper is to draw attention to the differential diagnosis of seminal vesiculitis and prostatitis and to show how acute epididymitis may be the sequel of seminal vesiculitis, especially when gonococci are not present. It is my opinion that not enough attention is given to the differences between the two first mentioned subjects, and since this is true, the results of treatment are not all that is expected.

The *etiology* of seminal vesiculitis is almost always secondary to infection from the gonococci, streptococci, staphylococci, colon bacillus, influ-

enza and sometimes tuberculosis. Contributory causes are masturbation and tonsillitis.

Pathology. In acute seminal vesiculitis the walls of the vesicles are greatly distended, much reddened and indurated and the contents usually contain pus and the bacteria that produced the infection. Sometimes the contents are very thick and of a bright red color, while at other times they are of a rusty brown; in the presence of suppuration they are mucopurulent and often contain epithelia, connective tissue cells and pieces of spermatozoa. In the chronic form, the one which we have to deal with most frequently, a somewhat different picture is presented. The walls are rather thick, indurated, or else very much contracted, and contain a great deal of interstitial tissue, and, third, the vesicles contain mucopurulent plugs which block the entire vesicle, and the contents will have so distended the walls of the vesicle that it assumes very much the same gross picture as that of acute seminal vesiculitis.

Guiteras divides the pathology into catarrhal and interstitial. In the class of cases where treatment has not been given, organization takes place in the vesicle and the walls contract down upon the contents, which give it a very nodular appearance, which on first examination might easily be mistaken for tuberculosis.

Symptoms. The symptoms are about the same as in prostatitis. Pain in the perineum radiating into one or both thighs, and in the early stages frequent priapism, followed later by diminished sexual desire and sometimes complete loss.

Urinalysis shows a great many long threads and mucus plugs. Upon massage a brown or dark red mucopurulent substance may be expressed and a great deal of pain may be experienced by the patient in the right lower quadrant of the abdomen, especially in the appendiceal region.

It is not uncommon to find seminal vesiculitis in boys between the ages of sixteen and twenty-five who have never experienced a Neisserian infection, nor is it uncommon to find seminal vesiculitis without the patient's being aware of its existence.

The *diagnosis* can be made upon rectal examination, the symptoms and the microscopic examination of the contents expressed.

Treatment. In the treatment, high massage, stripping the vesicles about every four days, occa-

sional bladder irrigation, rectal irrigation with discretion, and Sitz baths twice daily from five to eight minutes at a time.

The surgical treatment consists of vasotomy with injections of 20 per cent argyrol, and drainage of vesicles.

The prognosis is good.

ACUTE EPIDIDYMITIS.

The *etiology* of acute epididymitis is usually secondary to a gonorrheal infection, and may be secondary to any infection in the vesicles.

Pathology. In the pathology of acute epididymitis we must consider the epididymis nothing short of a tube divided into chambers and as the beginning of the vas deferens. Any infection in the vas naturally would produce a focal infection in the globus minor of the epididymis and may continue to infect the different chambers of the epididymis, thus producing very much thickened, indurated and enlarged glands in the region of the epididymis and testes, hence, a congestion in all the blood vessels supplying the epididymis and testes.

The epididymitis has been considered for some time as the cause of the enormous amount of pain which the patient suffers when this condition exists, but this is not true, for the following reasons: Upon observation, we find that the infection does not necessarily remain entirely in the epididymis, but will follow the seminiferous tubules from the epididymis to the testicle and thereby produce an orchitis, and again, the orchitis will produce pressure on the tunica albuginea. As a result of the congestion of the glands in the inguinal region they cannot carry off the blood rapidly enough, and consequently there is a stagnation which produces free fluid in the tunica vaginalis, or a hydrocele. This pathology does not exist except in the severe cases, and when this condition is present the different covers between the tunica vaginalis and the skin are under the greatest tension, as will be shown later in this paper.

Symptoms. The symptoms of acute epididymitis are divided into two classes, mild and severe. In the mild form there is some redness and swelling over the epididymis, slight temperature, increased pulse and some pain, while in the severe form the symptoms are, first, excruciating pain, a great deal of redness and swelling, due to the tension, particularly on the surface not

only of the epididymis itself but upon the testes proper, and the pressure within the seminiferous tubules.

In this class of cases the infection has migrated from the epididymis proper into the seminiferous tubules and has already reached the glandular substance of the testes, thus producing the pathology already mentioned, and the various layers between the skin and the tunica vaginalis are under great strain.

The *treatment* is divided into two classes, palliative and surgical. The palliative is used in the mild form, while the surgical is always used in the severe form. The technic of this treatment is to divide the skin and the various layers down to the tunica vaginalis and separate layer by layer one from the other so as to relieve tension. The tunica vaginalis is opened, the fluid withdrawn and the lower pole of the epididymis opened with a fine bistoury, the pus expressed and a cylindrical gutta percha drain inserted. The wound is closed in the ordinary way and suspension used from twenty-four to forty-eight hours, thus rendering the patient entirely free from pain.

TUBERCULOSIS—A MEDICAL SPECIALTY THROUGH POPULAR DEMAND.

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Internists and general practitioners have been very reluctant in the past to accord to tuberculosis the dignity of recognition as a medical specialty. One of the war horses of medical education, when it was suggested that the medical college with which he was connected create a chair of tuberculosis, made a show of great disdain and replied: "Next it will be urged that we establish an endowed chair on piles." And so his medical college continued as it had in the past, and as many other medical colleges still continue to do, to devote little attention to tuberculosis in general and even less to the early diagnosis of pulmonary tuberculosis, upon which all successful management and treatment of the disease depends.

It is quite unnecessary, at this time, to dwell upon the general neglect of this vitally important subject in the past or to comment upon the

very hazy idea of the disease possessed by the average physician when he sets forth in the practice of his profession. Nor is it profitable to dwell upon the lack of interest usually manifested by the general practitioner as, year after year, he has met the never ending procession of consumptives in his professional work. Nor, incidentally, is it necessary, in these pages, to remark upon the skill and painstaking care essential to the diagnosis of tuberculosis in its earlier stages.

Of my recollections of my own medical school days, I can recall rare nervous afflictions which I have never seen in the twenty years which have elapsed since that time and strange skin diseases which I have never encountered or which I have never been able to recognize, and yet I do not recall any special stress being laid upon tuberculosis or any instruction on the diagnosis of the disease in its early and curable stages. The description of phthisis given me at that time, as I recall it, was the terminal chapter of the story which might have proven valuable as the preface to autopsy notes.

At any rate, I clearly recall that I left medical school with the impression, gained from my course of instruction, that, from the standpoint of the physician, either typhoid fever or appendicitis was more important than pulmonary tuberculosis.

With so slight attention accorded to a disease which causes one-eighth of all human deaths and, perhaps, directly or indirectly, one-eighth of all human illness, it is hardly to be expected that it would be dignified by any special recognition in the course of but two decades unless there had come about an actual revolution of thought.

There has come a revolution of conception in regard to tuberculosis—a radical change in attitude—through which the diagnosis, treatment and management of the disease have come to constitute in fact a distinct specialty and that change in conception and attitude constitutes one of the most remarkable and interesting chapters in the history of modern medicine.

A medical specialty, as I understand it, is a branch of medicine requiring exclusive application on the part of the practitioner to permit him to develop the high degree of technical skill essential to his successfully engaging in it. Measured by this definition, tuberculosis is essentially a specialty since, regardless of the details of diagnosis and treatment, whose mastery is rare

enough at best, its successful practice involves a combination of medicine, social viewpoint, psychic influence and individual management found nowhere else in medicine, unless it may be in the public side of pediatrics or in the treatment of mental diseases.

A more practical, if not commercial, definition of a specialty is a field of medicine in which the demand is so general as to warrant or require the full-time service of considerable numbers of physicians to meet the public need. Measured by this definition, tuberculosis stands out throughout the entire Nation, and particularly in Illinois, as a specialty of the first magnitude.

Within the past two years forty-one Illinois counties have voted on the proposition of establishing tuberculosis sanatoria, free to rich and poor alike, together with tuberculosis dispensaries and visiting nurse service for the tuberculous, and the sentiment of the lay population is made clear by the fact that forty of these forty-one counties adopted the measure by overwhelming majorities. Thirty-three of these counties submitted the proposition at the autumn election of 1918 and of these all declared their approval of establishing sanatoria, in some communities by a vote of six to one.

And now these counties, which have taxed themselves hundreds of thousands of dollars to establish the machinery to meet their gravest medical problem, are confronted by the fact that a sufficient number of physicians, proficient in the diagnosis and treatment of tuberculosis, is not available for these sanatoria and dispensaries. The situation is quite as unusual and perplexing as though forty hospitals for major surgery had been suddenly created in a state of wide area in which barely a handful of physicians made any pretense of practicing surgery or manifested any genuine interest in it. We recall the oft-repeated assertion of the late Theodore B. Sachs: "It is far easier to raise money and to build tuberculosis sanatoria than it is to secure physicians capable of conducting them."

With the present tremendous popular interest in tuberculosis, it is not at all unlikely that the remaining sixty counties of Illinois will put the sanatorium proposition before the people two years hence and, if so, it will probably carry in every county. In that event, over one hundred Illinois counties will require the services of phy-

sicians proficient in the diagnosis and treatment of tuberculosis.

And this brings us to consider the peculiar development of tuberculosis as a medical specialty.

As a rule, medical specialties are developed within the medical profession, and the services of these specialties are offered to the public, by which they are accepted, at times, with a certain degree of reluctance. The physician who desires to practice a specialty often finds that he must knock lustily at the door and must pass through many lean years, regardless of his fitness or ability. The attainment of admission to or recognition by some of the more exclusive special medical societies constitutes a difficulty, if not a barrier, to many ambitious young men.

Interest in tuberculosis, on the other hand, has developed largely outside of the medical profession, guided, of course, by a comparatively small group of medical men to whom we are indebted for the advancement of the scientific side of the subject to a point that is more than creditable. The general public have continued to agitate the tuberculosis problem until they have provided remarkable medical machinery for which they are asking the medical profession for expert guiding hands.

The people have awakened to the fact that tuberculosis is not an inevitable scourge. They have become aroused from the lethargy in which they accepted this preventable and curable disease as a matter of course. They have been taught, by their own tragic experiences, that the successful handling of tuberculosis requires something more than they have been receiving from the medical profession in the past. They believe that the requisites are greater knowledge, greater skill or, at any rate, greater interest on the part of the doctor and, in so believing, the public have created a medical specialty ready and waiting for the medical profession to man when the medical profession are prepared to do it.

It is not a specialty full of golden promise. It is one in which the physician of commercial tendency, or without social outlook, is likely to fail. It offers only moderate monetary recompense. It offers, however, an opportunity for distinct public service in a specialty uncrowded and in a field so neglected in the past that it is pregnant with possibilities for scientific development.

The popular interest in tuberculosis has caused to be placed upon the gate-post of every large county or populous community a sign which reads: "Wanted! A Man!"—which marks a splendid field for the highest type of professional skill if coupled with the cleanest type of social conscience.

It is rather unique, in the present over-crowded condition of general medicine, to find a specialty ready-made and waiting for workers. It is also unique in the annals of medicine to find a field of special medical activity so wide and so definitely prepared that those already engaged in it are urging others to join them in their tremendous undertaking.

INFLUENZA VERSUS THE EPIDEMIC.

An Etiologic Resume.*

ALBERT J. CROFT, M. D.,
CHICAGO.

It is a well recognized fact that since life was created on this earth the phenomena of epidemics have always been in close relation, occurring at certain intervals and have always been the factor in causing marked reductions in the World's population.

Are they disturbances which mark the closing time of a certain type of civilization, or of a certain type of man, just as upheavals of the earth have marked the closing date of various ages?

That an epidemic is of value to human progress is left to be seen. Geologically, however, the good is evident, the revolutionary changes which have occurred in the bosom of the earth from Archæan to Cenozoic times through the various ages have always been followed by progressive changes in the surface of the earth and the replacement of one type of life by another, hence, we have the age of invertebrates, fishes, amphibians, reptiles, mammals and alas! man.

Throughout the ages primitive animals and plants have been continuously wiped out always to make room for higher developed species. This process of elimination has been due to mechanical, chemical or thermal means, and recently it is claimed bacteria have been found in fossil remains, so we may even say they contributed to the good work.

I am not sure, however, that after an epidemic,

that after a wiping out of a great number of human lives whether the new generations of replacement have been endowed by any special gifts which would characterize them as higher developed species. I am, therefore, not inclined to accept the evolutionary changes of nature as a grade of progress when applied to ourselves but to consider such changes as always abnormal. Let every man live the life of his arteries. The doctrine of "let nature do the work" as advocated by some of our public health officials, does not appeal to me.

Epidemics have occurred in past ages just as they are occurring today. In pre-bacteriologic times, when a physician who dared to associate a living organism with disease would have been considered a lunatic, a fanatic, a criminal and probably condemned to death.

In these days of the microscope and bacteriologic technique thought has changed and we find the reverse conditions; we think of bacteria only and a physician who associates a disease with anything but bacteria is said to have lost his "ball bearings." How will the future medics look upon us? Probably just as we look upon the members of the past generations. For they undoubtedly will have a new fad.

The various reports regarding the etiologic factor of the present epidemic which I am about to summarize and the extensive efforts made by the various investigators to find a germ to suit the occasion has already resulted in accusations against the streptococcus, pneumococcus, micrococcus catarrhalis, and a few others leading to a world of confusion and chaos.

The term "Influenza," which means "influence," was adopted by the Italians in naming a disease occurring in epidemic form during the year 1743, and since that time many epidemics have been placed under the Band of the "Influence."

During the pandemic of 1890 of a disease similar in nature to that of the Italians of 1743, and which was also called the "Flu," Pfeiffer's exhaustive investigations into its cause resulted in the discovering of a small coco-bacillus which was generally accepted at that time as the etiologic factor, and we have been taught since then to associate this organism with a train of pathologic phenomena, a specific disease—Influenza. This organism, which was found in the sputum and on the surfaces of the respiratory tract in a

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large per cent. of the cases, seemed to have settled the question of the bacterial nature of influenza. However, the acceptance of the influenza bacillus as the causative factor of this epidemic is meeting with considerable opposition on both sides of the Atlantic.

Little, Garafalo and Williams,¹ Canadian Army Medical officers, in making examinations of smears and cultures of sputum and exudates from the upper respiratory tract in cases during this epidemic report that the most important and constant organism found was a small coccus which they considered favored in many respects the Streptococcus. During this time Gotch and Wittingham² reported the presence of a "Gram negative" coccus not unlike the Micrococcus catarrhalis. They also report finding the Influenza bacillus in about 8 per cent. and a bacillus having similar characteristics in about 62 per cent., other bacteria such as the pneumococcus, and streptococcus being present. Because of the constancy with which these "Gram negative" cocci were found, implantations were made on the pharyngeal membranes of healthy persons and they claim symptoms of influenza had occurred in two persons. Those results led them to conclude that this organism is the cause of the present epidemic.

Averille, Young and Griffiths,³ also English investigators, on the other hand report a very high per cent. of Bacillus influenzae in smears from sputum with a "Gram positive" diplococcus predominating. The English investigators, however, seem to be chiefly concerned in discrediting the works of Pfeiffer and other German workers, since in France the Weekly Bulletin of the A. E. F.⁴ makes the following supportive statement:

"This disease which was mentioned previously as 'Three Day Fever' is now known to be due to the true Pfeiffer's bacillus, although evidently of a much milder strain than the type which prevailed in the pandemic of 1889." However, we must mention here that reports from Gruber, Freidman and Kolle⁵ from Germany show that they failed to find the B. influenzae.

As the disease appeared in America it is interesting to quote here the results of some of our American investigators. In the East, Keegan⁶ of Boston reports that he found a very high per cent. of the B. influenzae among the soldiers and sailors. Those high findings seem to have re-

ceived support since Park⁷ of the New York Health Department Laboratories also claimed to have found a high per cent. As the disease spread westward and in the various camps we find the highest B. influenzae findings were made by Tonney⁸ of our Chicago Health Department Laboratories who reports 12.4 per cent. in sputum. While Nuzum⁹ of the County Hospital found the B. influenzae in 8.7 per cent., contending that the pneumococcus was the predominating organism. Strause and Bloch¹⁰ of Michael Reese Hospital report 5.5 per cent., while Friedlander¹¹, working at Camp Sherman, found the predominating organism to be the pneumococcus in 53 per cent. of necropsies, hemolytic streptococcus in 47 per cent., and the Bacillus influenzae was not found more frequently than prior to the epidemic. Hirsch and McKinney¹² claim that the B. influenzae plays no important role in the epidemic.

Then Lord, Scott and Nye of Boston¹³ support this statement by saying, "There seems to be no justification for the belief that the epidemic was due to the influenza bacillus which is probably a secondary invader and bears about the same relation to the influenza cases as to respiratory infections of a different sort.

O'Connor,¹⁴ working on sputum from a large number of selected cases, failed to find the influenza bacillus in pure culture. Then Synnett and Clark,¹⁵ working at Camp Dix, make this significant statement: "It is by no means certain that the Bacillus influenzae of Pfeiffer is the original infecting organism. We have not found it in pure culture in any of our cases examined post-mortem."

From the bacteriologic findings one would conclude that this epidemic is either not a true Pfeiffer epidemic, that the etiologic factor of the epidemic of 1890 was never determined, or that the present disease is entirely different. It is evident that if any one specific organism is connected with the disease it is still entrenched so as to defy the efforts of our scientists. All kinds of organisms have been found in large and small percentages; are we then to infer from this that all of these organisms, many of which live a normal saprophytic life in our throats, become all at once pathogenic? and combined, produce the symptom complex of the present epidemic, or is there something chemic or otherwise which have changed the saprophytic environment permitting

all these organisms to enter a transition form? Investigators everywhere are agreed that these organisms play only a secondary role in the production of the pathologic changes, and are probably responsible for the terminal infections. Then, it is within reason to assume that the causes which changed the normal environment of these organisms in the throat may be in the realms of physics, geology, or chemistry and not merely a subject for the bacteriologists.

The question of the primary conditions which have changed these environments may not be organic life but probably may find expression in these sciences.

It is plainly evident that during this epidemic investigators have devoted their entire time in trying to associate some bacteria with the disease; no one, however, has given the subject of a primary non-bacterial cause a thought.

The reports from some parts of Europe show the influenza bacillus was seldom found and that the predominating organisms were the pneumococcus, streptococcus and micrococcus catarrhalis, while in the army abroad Pfeiffer's bacillus was considered the cause of the disease. The American reports also give the *B. influenzae* greater credit. One significant reminder is that this organism was a constant feature of the epidemic of 1890, while in the present epidemic the reverse seems to be the case. The influenza bacillus has been overshadowed by other germs which played no part in the epidemic of 1890.

It is evident that if the disease is the influenza of our school days it is not due to the bacillus and that if it is the same disease that occurred in 1890 the association is obscure.

I have not been keen in accepting the bacterial theory of disease in regard to this epidemic for two reasons:

1. Because of the extreme rapidity with which it has spread all over the globe at a time when it was generally known that ocean going traffic was at a standstill.

2. And because of the nature of the disease which appears to assume the characteristics of some chemical poison. Indeed it may be likened in many of its features to caisson disease.

You will agree with me that fever is not a constant sign while headache, dizziness, faintness, nausea and vomiting and pains in the extremities are more or less characteristic. It seems that the cause, whatever it may be, has a

direct action on the respiratory tract, there being congestion and hemorrhage.

A very significant statement was made by the British Medical Research Committee¹⁶ in regard to the spread of the disease. "Epidemiologically," they say, "the extreme contagiousness of the disease was proved to be due to its aerial convection, namely, by means of the 'drop infection' from person to person, and not by transportation of the virus through the air at large, through winds." From this we may infer that direct contact more or less is the factor. Coutant¹⁷ states that so far as can be determined the epidemic began in Manila. This opinion is based on the statements of Castellani and Chalmers that pandemics of influenza have usually started in the far East. He further states, "all of the reports and rumors of influenza occurring elsewhere, that have come to my attention, have placed their outbreaks at later dates than the one at Manila with one exception: Between 30 and 40 cases of influenza, with at least one death, occurred on a United States Army transport which left San Francisco shortly before the epidemic in Manila."

In my preliminary article I made mention of the fact that even vegetations had suffered and now come reports from the Canadian wilds that the game in that region is suffering from a disease similar to that occurring among human beings; the animals were found to be in a weakened condition, unable to resist the hunters; the lungs of those killed were found to be congested. Of course the disease noted by hunters may be analogous to the disease occurring in domestic animals known as equine influenza, pink eye, catarrhal fever or mountain fever. Animals have suffered to a great extent during this epidemic and it may be said that conflicting opinions as to the real nature of the disease has placed it in the same doubtful category of human influenza. Sheep herders in Montana who are practically isolated from civilization, as a rule not even receiving the newspapers, are reported to have rapidly become ill with the disease.

Baboons and other animals are said to be suffering and dying from the disease in South Africa.

It is clearly evident that the various bacteriologic investigations conducted abroad and in this country in regard to the etiologic factor of the present pandemic has resulted in such a division

of opinion that we may conclude the bacterial cause of the present disease is still an unknown quantity. This may be due to either inadequate knowledge on the part of the bacteriologists to attach the blame to one of their favorite bugs, or that the present epidemic of the disease of the respiratory system is due to conditions which are yet unexplainable and probably non-bacterial.

The organisms which have been found from the various excreta have all proved conclusively that they were responsible for the secondary and terminal infections, but what about the primary excitant? To say that it is due to a filterable virus or to some organism yet to be discovered is not reasonable. Why don't we try some other means of ascertaining the cause? Why should we only rely on bacteriology?

In considering the causes of disease, if we were to place as much emphasis on geologic and chemic influences as we do on bacteria it is probable that we may find the condition—say some atmospheric change—which would explain this widespread pandemic.

In my preliminary article I referred to the so-called epidemic influenza disease as probably due to a highly irritating, high density gas occurring in the atmosphere, while I had performed no scientific investigations to prove such was the case, outside of the suggestions of the nature of the gas which was made and the kind of atmosphere which I had observed. I wish to say I am of the opinion that all bacterial diseases are really only secondary diseases and must depend upon some primary factor and that bacteria as an organic entity can do no harm unless the conditions of the body warrant its nutrition. That they live on our skins, that they are present on the mucous membranes of our respiratory system, nobody can deny, and who can say that we do not also carry filterable viruses in these locations?

So the question of a germ or a filterable virus does not concern me. The questions I would like to have settled are, "What are the conditions which occur at certain intervals which make these organisms virulent? What are the conditions which favor these germs to incite an epidemic? Even if we found an organism in this epidemic and label it the cause as Pfeiffer did in the epidemic of 1890, would we be able to explain the reason for its appearance?"

In conclusion I wish to say that more thought

and study should be given to influences which make our normal living environment favorable for growth and development of pathogenic bacteria. We must discover the wound in this epidemic which has permitted them to secure such a firm grasp upon our system.

A great deal probably would be accomplished if geologic, chemic and meteorologic surveys were made in conjunction with bacteriologic examinations. We must find the causes which undermine our systems and make us susceptible to bacteria.

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DISCUSSION.

Dr. Tice: With every epidemic or pandemic, unusual opportunity is presented to apply the newer methods of investigation and to advance our knowledge. The present pandemic, the most extensive in medical history, is not an exception. It is not unreasonable to expect that much might be accomplished and many of the problems associated with great pandemics made clear. Apparently the very reverse has occurred, at least in more than one respect. One of the acknowledged achievements in the '89 and '90 pandemic was the isolation and demonstration of the Pfeiffer organism. So far as one can judge, in the present pandemic, this organism has had only a minor part. In fact there is good reason to doubt whether it has had any etiologic influence. The laboratory reports are so conflicting that some doubt has occurred as to the causative factor. At the present it would appear that the Pfeiffer organism has been quite generally discredited, and while many others have been found, no specific one has been demonstrated. This, however, does not constitute sufficient ground to discard the infective nature of the disease. To do so would be a step backward. At the same time it can hardly be denied that many contributing factors are probably present. Before the days of bacteriology much emphasis was placed on climatic, atmospheric and similar factors. The history and reports of the previous similar pandemic are filled

with just such observations. Even the name Influenza, abbreviated at present to Flu, is a relic of the previously accepted belief that the disease was produced by the influence of cold. The name Influenza was first employed in 1743 by Pringle and Huxham, derived from influenza di freddo, influence of cold or influence through atmospheric phenomena. To accept such a view at present is no longer possible, only to the extent of a contributing factor.

Variation in the type of organism, as well as the degree of virulency, difference in body culture media, the variable amount of immunity, as well as the many contributing external factors, probably must account for the "protean" manifestation of the present pandemic.

Dr. Chvatal: I am glad to be present tonight. The idea that this condition was due to some irritating substance in the air had been one which I long had in mind. However, I wanted to hear some one talk about it so that I would be convinced that I had really noticed something in the air. Dr. Croft's theory of a gaseous irritant hovering somewhere in the atmosphere, like that which at times originate in the stock yards, is a very plausible one. I do believe that some one should study atmospheric association with epidemic disease of the respiratory tract more fully and give us some information of abnormal properties which it may possess during these epidemics. A germ in my opinion is harmless, no matter how pathogenic it may be unless something paves its way.

Dr. Graves: I wish to say that Dr. Croft's remarks were decidedly sane, if not correct. I think there is value along these lines. What the real truth is and what part the germs take in the disease or the diagnosis, I do not know. There are many of these considerations that furnish hypothesis that produce results. The same as in chemistry. I personally can't help but feel that the present epidemic is due largely to some kind of irritation. There may be something in the condition of the atmosphere that distributed the disease. I had several families where members of the Great Lakes brought the disease. There are also a number of people from the South who left the camps, came home on the trains and became ill. Those cases, my idea, became affected, not infected, while being out on the train. The epidemic of Grippe thirty years ago, we all know was followed by successful outbreaks. Otherwise, I do not feel that I can throw any light on the subject.

Dr. Auerbach: The present epidemic seems to change according to the weather conditions such as the fog. I have noticed that the Influenza epidemic has been particularly severe during the foggy weather in Chicago the last few months. Will some one give a reason for this change?

Dr. Yerger: I want to congratulate the doctor on his paper which reviews the etiology of this epidemic. I must admit that I know nothing about it. In fact, we all know very little and nobody as yet has told us what the real microbe is. I do not agree

with Dr. Croft that this is not an infection. I am not a bacteriologist, but there are several unexplainable facts which make me feel that it is an infection. In regard to the weather I found that the number of cases increased when it was foggy and damp.

Dr. O'Connor: The doctor states in his paper that the chief concern of the English was to discredit the work of the German investigators. I say he is guilty of the same sin when he says he does not believe in the bacterial theory. As a bacteriologist, it is hard to understand people who cannot see things our way. I presume the same rule applies to the chemist, the surgeon, the therapist, etc., and must admit therein lies our greatest mistake. There are men in Germany who could talk quality, composition and uses of aniline dyes all day without making serious inroads into their stock of knowledge; to study any other branch in the minds of such individuals would be treacherous to the cause. That is probably our trouble. We have been studying only one angle of the etiology. I agree with the doctor that something must precede the germ and give it leeway. I may incidentally add, however, that the toxin of a germ if highly virulent even excreted in small quantities in certain individuals may be the forerunner to lowering the vitality and thus open the favorable conditions for the vigorous development of the organism, but the individual must harbor the germ. I have been particularly interested in this epidemic and I have had the opportunity to study the sputum and other secretions in my laboratory. To say that the so-called Pfeiffer bacillus, if such an organism exists and is not really a transition form of the coccus family, is the cause no intelligent bacteriologist who has had experience during this epidemic would say, since we have found this organism in no greater numbers than have ordinarily been observed in sputum and other pathologic material at other times. Even in the epidemic of 1890 Pfeiffer's association of his organism with the disease met with considerable opposition so it is still doubtful whether the bacteriologic cause of that epidemic was established. I may mention here, however, that his organism was a dominant feature occurring in a much greater percentage than have occurred during this epidemic. Faulty technique as a reason for failure to find the Pfeiffer's bacillus is out of the question as the technique of to-day is far superior. I heartily agree with the doctor that greater attention should be paid to the primary pathways of infection or the environmental conditions which favor the development, virulence and transference of pathogenic bacteria. We have reduced epidemics of typhoid, dysentery and cholera to a minimum because of a systematic study of water supplies. We have controlled malarial outbreaks because of the study of mosquitoes and their breeding places, the swamps. Aerial transmission, however, is a hard thing to control. I am a firm believer in fresh air, but at times it is loaded with pathogenic bacterial flora of other agencies of dis-

case and although it is "fresh" it is unwholesome. A study of the air as to its chemical and bacterial content with the object of devising some means of purification as we have done with water supplies would probably lead to some interesting facts regarding respiratory epidemics. The doctor's theory regarding an irritating gas may be perfectly correct, at least, it has given food for thought and will probably interest some one in devising means for the better study of the air and its subsequent purification. If an individual becomes wounded, there are only two ways possible to infect his wound. He may supply the germ himself from his throat, skin, etc., or it may be deposited on the wound by the air either directly or indirectly. I believe the same holds good with any infection, there must be something besides the mere presence of the germ which gives it leeway. So it is possible to see that his theory of a gas as the cause of the primary wound in this epidemic has merit. For who is here to prove that the air is not surcharged by a gaseous substance, a substance capable of irritating the mucous membrane of the respiratory tract and thus reduce its resistance to the many organisms which have been found in this epidemic and credited as secondary factors.

Dr. Croft (in closing): I want to say even laymen have recognized there is a change in atmospheric conditions, why can't science? Last Saturday night the air was typical and I got some of it myself. The following day, I was greatly depressed with pains all over. Was this a mild attack of the flu? What is this irritant which seems to be in the air? When it is chilly there seems to be an irritating cloud which hugs the earth, especially when the sun goes down, it comes like a blanket and next day the doctors are busy. The atmosphere which I have noticed is very damp, dense, stuffy, chokey and there is a slight perceptible odor. It irritates the mucous membrane like chlorine and clings to the earth like marsh gas. I advanced the theory of a gaseous primary cause of this condition about two months ago, and I still stand on the same ground. In my paper I have given the etiologic statistics to show that the condition is not due to a yet discovered organism so to term it influenza would be to say any typhoid-like condition was typhoid. To say that all the bugs in the universe are to be blamed for this epidemic is not getting anywhere. We all know that physical, chemical and thermal agents are the precursors of germ infection. The various organisms associated with this disease all are agreed are responsible for only the secondary conditions. I hold that a chemical agent in the atmosphere is responsible for the primary irritation which paves the way to bacterial infection. Now let some one prove the fallacy of this theory. Our scientific brothers call it a contagium. While it has traveled faster than the crow flies, who infected the eskimos in the inaccessible far North and the inhabitants of countries in the far South end of the globe at the same time that Europe and America was invaded? It is interesting to note that it is with the greatest

difficulty Roscnow's vaccine is being conveyed to the Eskimos. It is a well recognized fact by veterinarians that during or shortly after an epidemic of human influenza, domestic animals suffer from the equine type. The association between the diseased human and the healthy animal is evident, but who conveyed the disease to the wild animals of Canada and Africa? There are mighty few healthy humans who come in contact with them, much less a poor influenza victim. I would say in an epidemic of this type, when no strict quarantine of houses has been instituted, one of the great distributing infecting centers would be the postoffice. The mail carriers are taking mail to the people all over the city, and back to the post office where hundreds of people work. I have heard some one say leucopenia is characteristic but can this same diminished number of W. B. C. be due to a chemical irritant, not a bacterial toxin?

RED CROSS PRACTICE

Jerusalem (By Mail).—How American Red Cross physicians engaged in relief work here are accomplishing worth while results in the face of great difficulties—and what they are up against—is shown in a report just received here from W. S. Dodd, A. R. C. doctor working at Mejdcl in this section.

With two capable English trained nurses, and three native helpers, more or less useful, Dr. Dodd, his "hospital" housed under tents, performed 252 operations in seven weeks, besides giving medical examinations, treatment and counsel to hundreds of the destitute inhabitants and refugees.

His report says in part: "The work of the Hospital was of the plainest sort, it might be called primitive. About twenty-five tents comprised the Hospital proper, with a Dispensary tent, and tents for the living quarters of the staff.

"The soil was all the purest sea-sand with thistles and scant grass; going barefoot was the universal custom, and in our own quarters we of the staff used to follow that custom with great pleasure. * * * *

"The professional side of the work was of the greatest interest to me and every day was a pleasure. The clinics numbered sixty to a hundred a day. Of course we had all classes of cases in medicine and general surgery, but by far the larger proportion of our patients were eye-cases.

"Of the 252 operations that I did in less than seven weeks, 222 were for the eyes. This is the number of persons operated on, most of them having more than one operation, perhaps on all four lids, so that I really operated on 408 eyes.

"There were some Cataracts, not more than would be seen in the same number of cases elsewhere, but Trachoma and its consequences accounts for almost all of the eye troubles in this land. I set out to treat these cases radically and secured fine results when I could keep the patients long enough for a reasonable after-treatment. But even so, the number of eyes

(Continued on page 108)

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State society will pay no bills for legal services except those contracted by the Committee. Notify the Chairman at once. Do not employ attorneys.

FEBRUARY, 1919

Editorial

LEGISLATIVE MATTERS

We are informed by our Legislative Committee and others that the usual number of vicious medical bills are to be presented to the Legislature during the present session. Among these

objectionable bills which will likely be presented is one from the dentists, one from the optometrists, one from the osteopaths, one from the chiropractors and a compulsory health insurance bill. No doubt there will be others. The absurdity or viciousness of a bill is no surety of its not becoming law, and the only plan by which the medical profession can protect its interests is to be ready with its opposition and present such in force.

The dentists will present a bill, which, if passed, will prevent doctors from doing any work on the jaw. Think of the absurdity of the thing. The Dental society has already brought one suit in court to prevent doctors from doing work on the jaw. This was won by our Medico-Legal Committee. Now they propose a new law by which they will prevent work on the maxillæ by a doctor.

The compulsory health insurance bill, if proposed and becomes a law, will be a curse both to the profession and the people.

The chiropractors are seeking a separate board of examiners, which means another entrance to the practice of medicine. All of these cults are trying to gain entrance to medical practice without meeting medical requirements.

It is the plain duty of the medical profession to help the Legislative Committee in any way it can, and to furnish such help promptly.

OPPOSITION TO ANNUAL REGISTRATION

A wave of opposition to the annual registration of physicians, as proposed by the Director of the Department of Registration and Education, has sprung into existence. The Council of the State Medical Society at a meeting held recently in Peoria unanimously voted to oppose the proposed annual registration, and instructed each councilor to place the matter before each county secretary in his district, urging that county society to oppose the plan. The Council of the Chicago Medical Society at a recent meeting voted unanimously, with the exception of one vote, to oppose annual registration of physicians, and instructed its Public Relations Committee to resist the passage of any such measure. It seems that many doctors from all portions of the state are recognizing the offensiveness and dangers of the proposed plan.

The opposition is not directed at Mr. Shepardson personally, as it seems every one thinks he is an estimable gentleman of high standing. The very fact that such a strong opposition to his plan of registration is developing in spite of his personal popularity is excellent proof of the undesirability of the measure. If Mr. Shepardson's tenure of office were permanent and not subject to political change, some of the objections would, no doubt, be minimized; but Mr. Shepardson should not place the profession in an hazardous position, unable to readily extricate itself from a venomous board when he in all probability will not be associated with the Department.

Whatever other objections there are to the plan of annual registration—and there are many—there are two which all physicians must resent, namely, that of being classed with the various trades, such as barbers and horseshoers, and that of paying the financial burden of the Department. Mr. Shepardson should be criticised severely by the profession for his statement to the effect that the medical profession should not be held in higher respect or in a higher class than the horseshoer or bricklayer. One might ask Mr. Shepardson if the college professors should be registered annually so that the Department of Education might know in just which particular college each professor taught, and if the college professor should pay the burden of the Department of Education? Then also we would ask him if the college professors should be classed with blacksmiths and chiropodists, and if they deserve only to be so classified? Inefficient pedagogy is a most inexcusable and a most expensive community blunder. Why not register them annually? Today the prospective medical student must have sufficient education to pass pedagogic examinations before he is able to gain entrance to a medical college, and then he must put in another five or six years in college and hospital before he is allowed to be registered as a physician. When he has accomplished all this Mr. Shepardson intimates he deserves no better classification than the barber. This is all sufficient to condemn the plan.

Add to this the authority and power of a lay board to cancel a physician's license if he does not register at a certain time—to wipe away in one moment what it has taken the doctor years to obtain—and you are certainly adding "insult to injury."

Mr. Shepardson's one argument is that under a plan of annual registration he will know where each doctor is located, and that he can more effectually prosecute quackery. We may be pardoned for stating that annual registration of physicians will not give the Department any more power or authority than it now has for prosecuting quackery. The public only is benefited by the prosecution of quackery, and should therefore pay for such service; and furthermore, it is the duty of the Department of Registration and Education, as it is now instituted, to prosecute illegal practitioners, and the Department should not ask the profession to further pay them for performing their official duties.

We do not say these things in animosity. We simply do not want to jeopardize the individual licenses of the profession, nor do we want unjust taxation. It is the principle we are opposing.

ANNUAL REGISTRATION OF PHYSICIANS

ACTION OF THE COUNCIL

At a regular meeting of the Council of the Illinois State Medical Society, held at the Jefferson Hotel, Peoria, January 21, 1919, the question of the proposed change in the laws which would require the annual registration of physicians was discussed at length, and the following resolutions were unanimously adopted:

WHEREAS, The House of Delegates of the Illinois State Medical Society, including some members of this Council, at the Springfield meeting in May, 1918, was put "on record as being in favor of the Medical Registration Act"; and

WHEREAS, At the time of this expression there had been no definite plan for such annual registration, but rather a vague and uncertain proposition for such registration; and

WHEREAS, A more careful study of the proposed plan, after its full development, disclosed the fact that it has many objectionable features; therefore it is

Resolved by the Council of the Illinois State Medical Society, in session at Peoria, the 21st day of January, 1919, That it is the duty of the medical profession of the state to oppose the adoption of the proposed measure for the annual registration of the physicians of this state, and as

a justification for such action presents the following "reasons":

First—The indorsement of the proposition by the House of Delegates was made before a sufficient time had been given to a consideration of all its features.

Second—Because under the provisions of the Act, as now presented, it is well within the powers of the Department of Registration and Education to suspend the privilege of any physician in the state to practice his profession because of a simple failure to make the proper returns within the specified time, and to place upon him the burden of proof of his right to practice his profession in the state, with all its incident costs and annoyances, including decline of practice on account of the necessary litigation which must follow in order to restore him to "good standing" in the state.

Third—The principal object of the proposed measure is declared to be the protection of the public from quackery and fraudulent practices by the unqualified; and it is unfair, unjust and an unwarranted assault upon the rights of a profession which now stands, and has always stood, for the highest principles of right and justice in dealing with the public; has always supported measures designed to better the health of the people; has never advocated any measure for the benefit of the profession only, to now demand that it shall bear the burden required by the people to protect them from the assaults of quackery.

Fourth—It seems in order to call attention to certain facts in regard to licenses of physicians in the state of Illinois. The laws of the state require the physician to be a college graduate before entering the medical school; to attend such medical school four years, with the addition of one year in hospital service; to take an examination before a competent board under direction of the Department of Registration and Education, whereupon, if the examination is satisfactory, a license to practice medicine and surgery in this state is granted. *This right it is now proposed to take away upon a failure to renew each year at the specified time.*

Fifth—We do not believe that the proposed act would be any more efficient in the control of quackery than the present Medical Practice Act, if rigidly enforced, and we earnestly protest

against penalizing 10,000 reputable physicians in the state of Illinois in order to eliminate a few quacks who might very well be prosecuted under the present laws.

In view of the facts and conditions herein set forth, it is earnestly urged upon the members of the county societies to meet at once and discuss the question of the "Annual Registration of Physicians," and to take such prompt action against it as in their judgment may seem fitting, and to inform the senators and representatives in the Legislature of their position, and to urge the strongest opposition to this proposed assault upon the long established rights of the profession.

C. F. BURKHARDT,
C. E. PRICE,
C. W. LILLIE,

Committee.

SHALL THE MEDICAL PRACTICE ACT BE AMENDED?

PUBLISHED BY AUTHORITY OF THE CHICAGO
MEDICAL SOCIETY*

In a published article circulated in pamphlet form (printed by authority of the State of Illinois), Mr. Francis W. Shepardson, Director of Registration and Education, Springfield, Illinois, sets forth his views upon this subject. Mr. Shepardson says: "The officers of the Department approached the work of enforcing the Medical Practice Act without any bias, but, confessedly, with something of the accustomed reverence for medicine as a great and honorable calling, represented by men of far more than ordinary professional ideals. They expected to find a medical nobility, with a lively appreciation of its obligation to protect its honor. They confidently looked to find the drawn sword and the defending shield bearing the significant words, 'No one attacks our profession with impunity.'

"But this is what they actually found, during a year's experience and study:

"They found a poorly organized profession, with less than half of its members associated with its State Society, and with no clearly outstanding champions ready to tilt their lances against foes of medical honor."

A little further on after enumerating a score

*Approved for publication by the Public Relations Committee of the Chicago Medical Society.

or more varieties of quacks and medical parasites which flourish in Illinois, Mr. Shepardson gives his estimate of the medical profession in the following words: "The plain, unvarnished, easily supported truth is this: There are more fakers and charlatans in medicine than in all other professions and trades put together. There are more irregular, improper, indecent and immoral things connected with medicine than with all the rest. There is less real reason, so far as conditions in Illinois are concerned, for medicine to claim nobility and plume itself because of its high estate than there is for almost any occupation followed in the commonwealth by the sons of men. There seems to be no medical nobility which feels any obligation. There seems to be no champion, either individual or corporate, that is quick to resent attacks upon medical honor."

In his expressed contempt for the physician, as such, the Director of Registration and Education displays the mental attitude that has come to be characteristic of the professional politician, especially one ensconced in an appointive position. The disparagement of the medical profession which characterized the earlier part of Mr. Shepardson's article was evidently so satisfactory to the author that he is impelled to make sure that there shall be no misunderstanding about his estimate of the physicians of Illinois, for in one of his closing paragraphs he says: "But two objections have been made to the proposition as it has been discussed with many prominent individuals. One has already been sufficiently considered, namely, the alleged superior dignity of the medical profession when compared with others. As a disinterested layman, it is my frank opinion, for the reasons already set forth, that there is absolutely no basis, except possibly an historical one, for any such pretensions."

Having thus established that all the physicians of Illinois, with the possible exception of a few who are now dead, are of very low character, part of them because they are quacks and the rest because they permit quackery, this "disinterested layman" modestly asks for arbitrary power annually to confiscate every Illinois physician's license to practice, which, upon the payment of a fee of \$2.00 he may restore, depending of course on how he may happen to feel about it.

In speaking of the types of offenders wherein the present law empowers his department to re-

voke licenses, the Director of Registration and Education complains that, "For example the rumor that a physician is guilty of abortion is not sufficient ground upon which a license may be revoked"—the inference of course being that with arbitrary power to withhold licenses, rumors would be given their proper standing.

The versatile Director of Registration and Education implies that the physicians of Illinois are a craven lot utterly devoid of ideals and "too little interested to help in creating public sentiment in support of law and decency"; and to prove his charge that the medical profession is incapable of resenting any gratuitous and defamatory attack, proceeds himself to make one that from beginning to end is extremely uncomplimentary. As further evidence of the depravity of the organized part of the medical profession the Director could consistently point to the fact that he is permitted to appear again and again upon the programs of the County Medical Societies, there to repeat his assaults upon the medical profession, unaware that he is mistaking courtesy to a guest for a lack of sense of honor, that the physician from tradition "suffereth long and is kind" and is prone to assume that "no gentleman will affront me, no other can." But be patient, Mr. Shepardson, the physicians of Illinois are waking up.

Nowhere in his remarkable "address" does the Director of Registration draw any sharp distinction which may be applied to any considerable number of practitioners, between the reputable physicians who make up the membership of the State Medical Society and that motley array of parasites that does not and cannot gain membership therein.

The Director carefully avoids giving proper credit where it is rightfully due, for the progress in medical education, and the raising of the standards whereby the medical colleges of Chicago were reduced from 14 to 5, all of which was done by the medical profession and from within the profession long before Illinois had its "Civil Administrative Code" or the office of Director of Registration and Education had been created, long before any imperious Director or Physician-baiting Superintendent of Registration had begun to scoff at the dignity of the profession, one of whose members no doubt stood by for him, to assuage the suffering and to make safe the ordeal during those greatest hours

which come but once in human experience. This member of our profession may have been paid something, but he was not compensated.

At no time has there ever been any law in Illinois which conferred upon the medical profession any control whatsoever over who shall have the right to practice medicine. Whatever has been accomplished along this line has been the result of begging the legislature. Physicians of standing and influence are rarely found among the members of this body. The prevailing influence there is now and always, the lawyers, which may account for the fact that the Director of Registration and Education is not now seeking to extend the beneficent ministrations of his Department so as to include the annual confiscation of the lawyer's license to practice.

The Director of Registration pleads for an annual registration for physicians in order that it may be easy for his department to get the physician's license to practice away from its possessor, in fact it would require no effort whatever as said license would terminate automatically at the end of one year.

There should be no easy way of taking away the physician's license to practice. No bureau or department should ever be endowed with arbitrary power to revoke licenses.

When it is considered what it means to earn the right to practice medicine and surgery in Illinois, that twelve years must be spent in the secondary schools, at least two years in a College, and then four years in a Medical School to be followed by another year as interne in a Hospital, it is absolutely unreasonable to permit any Director or Department to have arbitrary power to terminate in some easy way such right to practice medicine and surgery.

Section 18 of the present law goes quite far enough along this line, and the judicious and efficient use of the powers the Department already has, will furnish work enough for the Department for some time to come.

Mr. Shepardson sums up his argument for annual registration for physicians in eight numbered paragraphs. Summing up this summary:

1-2. The Department does not have the correct post office address of all the legal practitioners of Illinois.

3. The physician who is practicing under an assumed name will give the right one when he asks for license renewal.

4. Permit the Department to cancel licenses without any ceremony.

5. The individual physician wouldn't miss the two dollars, but the aggregate amount, twenty-five thousand dollars, would come handy about the department, provided of course it could get it reappropriated.

6. Pay this small fee and keep still about it, or the fee will be made larger.

7. It is being done in other professions.

8. Many of the leaders of the medical profession think it a good thing.

The opposition to annual registration is summed up similarly, there being only two objections, namely:

1. The bogus dignity of the medical profession.

2. Inconvenience of writing a small check once a year.

The medical practice act no doubt should define more accurately and comprehensively what is meant by the practice of medicine. Likewise unprofessional conduct should be clearly and unmistakably set forth. Under the present act the Department of Registration and Education is clothed with all the power that should be entrusted to any such Department. Any closer supervision of the practice of medicine than is contemplated in the present act should be by a Director who is by education a physician, and the Civil Administrative Code specifically forbids that any such person shall be Director of Registration and Education.

There is just one colossal defect in the present Medical Practice Act. It was put there deliberately. The Department of Registration and Education knows it is there. Its continued presence there is a crime against the people of Illinois.

The Director of Registration has enumerated numberless forms of quackery without the law, quackery that flourishes in spite of the law, but for the most part the quacks, frauds and impostors thus enumerated are individual offenders against the law as it now stands, but never a word does he say about this one spot of gangrene in the Medical Practice Act, that legalizes the murder of little children, that licenses a systematic confidence game, that turns loose on the sick and suffering a horde of vultures whose promise to cure incurable disease is given legal

status, that protects the greatest fraud of all time in its gamble with human life, that opens wide the door of unrestricted admission, to the treatment, under promise of absolute and permanent cure, of every form of human ailment and suffering, mental or physical, real or fancied,—treatment charged for and collected for openly and publicly, that gives equality with physicians to an army of greedy and loathsome harpies whose only qualities are a mental twist and an insane desire for money, an army that with loud and blatant bellowing claims to know nothing of disease, that makes all the provisions and safeguards of the present law, but aids to this fraud now hiding behind the Medical Practice Act of Illinois.

Let the first amendment to the Medical Practice Act wipe out this stinkpot of iniquity, namely exemption number five of Section twenty. Section twenty defines the practice of medicine and exemption number five withholds the law from affecting "the treatment of the sick or suffering by mental or spiritual means without the use of any drug or material remedy."

Make Section twenty apply to the Christian Science Cult if its adherents accept pay for treating the "sick or suffering" or those who think they are "sick or suffering"—pay in any form, money or anything of value directly or indirectly given as compensation for such treatments—then this quack-infested commonwealth will at once, and at one stroke, be rid of more than half of the murderous horde of moral criminals that thrive by plundering the sick.

If there be any real religion in this strange thing called Christian Science it will be all the better for having been shorn of its mercenary feature. If this venal gang had any excuse for being, other than that of sordid money-grabbing, no such disgrace as exemption 5, Section 20, would ever have got in, to emasculate the Medical Practice Act.

CHAS. E. HUMISTON, M. D.

Correspondence

DO YOU WANT TO LOSE YOUR LICENSE TO PRACTICE?

The January JOURNAL contained an article written by Dr. Otto T. Freer opposing the proposition that there should be an annual registration

for physicians. If the conditions were as Dr. Freer suggests, the Director of the Department of Registration and Education would not ask for support of the plan. On the contrary, he would urge every physician in Illinois to oppose it. But it seems to me that Dr. Freer overlooked entirely the provisions of the Civil Administrative Code of Illinois. This code created the Department of Registration and Education. It gave to the Department certain responsibilities. It restricted the Department by certain definite and clear provisions. The code clearly sets forth seven groups of powers of a general character more or less common to a number of professions, occupations and trades. Then in express language it declares:

"None of the above enumerated functions and duties shall be exercised by the Department of Registration and Education except upon the action and report in writing of persons designated from time to time by the Director of Registration and Education to take such action and to make such report, for the respective professions, trades and occupations as follows: * * *

"For the medical practitioners, embalmers and midwives, five persons, all of whom shall be reputable physicians licensed to practice medicine and surgery in this state, no one of whom shall be an officer, trustee, instructor or stockholder or otherwise interested, directly or indirectly, in any medical college or medical institution. For the purpose of preparing questions and rating papers on practice peculiar to any school, graduates of which may be candidates for registration or license, the Director may designate additional examiners whenever occasion may require."

Under this law none of the dangers pictured by Dr. Freer could possibly threaten the profession in Illinois. No layman can grant or revoke or suspend a license. None of the individuals included in "ardent lay followers of osteopathy, Christian Science or other organizations inimical to the doctor," to quote Dr. Freer, could have power, since the law, in clear and specific words, declares that the power vests in "five persons, all of whom shall be reputable physicians licensed to practice medicine and surgery in this state." So long at least as the law of Illinois remains as it is, Dr. Freer's fears are without just foundation.

The Department of Registration and Education has no desire whatever except to advance the interests of medicine in Illinois. Its first

duty is to the people for whose protection the law is designed. It has something of obligation, too, to the ethical practitioners whose profession is injured by the acts of the unlicensed, the irregular and the purely fraudulent. It feels keenly the difficulty of trying to enforce the Medical Practice Act without having any means whatever of knowing who are entitled to the benefits of that Act. An annual registration would furnish the information desired. It would be the best possible protection of the reputable practitioner against the encroachments of the many who have no right to practice, for such might be detected at once on examination of the list of the registered. It would be a powerful aid in protecting the people. The plan of annual registration is strongly favored all over the country at this time, administrators in other states having exactly the same problems. Illinois should be kept in the forefront in all things which make appeal as essential to better administration in an age which demands efficiency.

FRANCIS W. SHEPARDSON,

Director of Registration and Education.

[EDITOR'S NOTE: We think Mr. Shepardson is mistaken when he states (in referring to authority to cancel licenses) "since the law, in clear and specific words, declares that the power vests in 'five persons, all of whom shall be reputable physicians licensed to practice medicine and surgery in this state.'" If we read the law understandingly, it says in effect that the Director of the Department will be advised by five reputable physicians, but it does not state that he must act as advised.]

To the Editor: The medical profession throughout the state seems to have "seen the light," and had a change of heart toward the proposed bill for annual registration of physicians. The Chicago Medical Society seems to be against it, as is the Council of the state society.

Would a big firm like Marshall Field & Company, or Swift or Armour leave their business defenseless and open to the whim of some official by consenting to register annually before they could do business in Illinois? What if some patent medicine manufacturer, who had grown rich robbing the people, should have political ambitions and be appointed on the "lay" board which would register us? What if he were a chiropractor, an osteopath or Christian Scientist?

This is not overdrawn. They would be eligible if they had the political drag to put their appointment over. Imagine Billings, Ochsner, Bevans or Patrick standing, with hat in hand, asking these mountebanks for a license to practice medicine!

Proposed medical legislation should spring from the medical profession, and not be served and cooked up by laymen. Again, I am willing to be watched and checked up by the general public, but I am not willing to pay the swivel chair artist's salary who does it in the form of an annual registration fee.

Boys, it's a gold brick. Let's leave it alone! Think it over!

H. P. BEIRNE, A. M., M. D.

Quincy, Ill., January 25, 1919.

To the Editor: I have read with a good deal of interest Mr. Shepardson's article in favor of annual registration of physicians; also several articles favoring the same, but more against it.

Personally, I wish to voice my strong protest against any such law or regulation.

It is claimed that the money received for annual registrations will be used for the prosecution of quacks and charlatans. It seems to me that the public would benefit by such prosecution and the money for that purpose should come out of the general taxation and not from special assessments against the medical profession. Annual registrations would be a nuisance and should not be tolerated or sanctioned by the medical profession for a single moment.

I trust that every medical man will think seriously about what it means and will use his influence with the lawmakers at Springfield with whom he is acquainted to have them see that no such law is enacted.

I commend most highly the sentiment expressed by your Journal, and appreciate the stand taken by the Council of the Medical Society in this matter.

Very respectfully,

WM. A. PETERSON, M. D.,

5039 Winthrop Ave.

HEALTH INSURANCE A NATIONAL FRAUD

The medical profession should not be deceived as to the real meaning or fail to realize the true

import of this gigantic fraud which has been a failure wherever tried.

The Hon. Francis Neilson, ex-member of the British Parliament and a student of political economy, speaking before the Chicago Medical Society, January 10, 1917, said: that social insurance in England is a dismal failure; that it was copied after the German system and that Germany's system is a failure. He says that one has but to investigate all conditions to prove it.

In the English work, entitled "Health and the State," by William A. Brend, M. A., D. B., B. Sc., there is much material showing that health insurance is a failure. Brend says that no one aside from the panel doctors is satisfied with the working of the English law. That the German law is a practical failure and that the English law is worse. It fails to provide competent care for those needing it. Some investigations showed that for making diagnosis three and a fourth minutes per patient was averaged by the doctor (page 179).

Sir James Barr, M. D., LL. D., F. R. C. P., T. R. S. E., Lt. Col. R. A. M., C. T. F., former president of the British Medical Association, in an article (American Medicine, October 8, 1918), entitled "Future of the British Race," says (page 651): "I would strongly advise the country to carefully scrutinize any scheme which is brought forward under the catchy title of ministry of health. The proposal so far merely points to the glorified extension of that *gigantic fraud*, the National Insurance Act."

Sir Bertram Dawson, in the last Cavendish lecture (British Medical Journal, 1918, 2, 23, 56) (from editorial, Journal of the A. M. A., December 7, 1918), speaking of the future of the medical profession in England, says: "It appears that the position of the physician in England is far from being an enviable one and that certain reforms are greatly needed. The physician is overworked and underpaid, and the influence of the profession as a whole in public affairs seems to be practically *nil*, even when they relate to matters in which the medical man should be the most competent to advise. This is indeed unfortunate not only for the physician, but also for the community. The present condition of the profession is not the result of the war, but the outgrowth of many antecedent conditions, not the least among which is the national health insurance law.

"Many physicians who are doing panel work under this law, even with hard work, are unable to earn more than £30 (\$150) net a year. While it is admitted that the panels might be made larger and thus yield greater return, this simply reduces the practice of medicine to a question of physical endurance, without regard for brains and ability."

There is much food for thought in this situation for those who without due consideration are urging state health insurance in this country.

Dr. Friedensburg, for a period of twenty years prior to 1911, the president of the Senate of the Imperial Insurance office in Germany, has given his views upon the practical results of working men's insurance in that country, and they constitute an indictment of the system. Some one, in summarizing the series of charges made by Dr. Friedensburg, points out the three most significant, as follows: "The first is that the state insurance, especially designed to replace pauperism and charity, is itself merely pauperism under another form. The second charge is that it has fostered to an incredible extent the German evil of bureaucratic formalism. The third and worst charge is that it has become a hotbed of fraud, and therefore a spreader of demoralizing practices and ways of thought."

As picturing the changing conditions in Germany as long as twenty-five years before the war the following by Mr. C. Piefke, the eminent German sanitary engineer, in a letter to Mr. G. W. Fuller of New York is significant: "Here in Germany conditions have changed to be very uncomfortable. Militarism and bureaucracy are spreading over our very existence, and despite all effort no success rewards him who does not occupy a high rank within this hierarchy. Then comes the unfortunate passion for title among Germans in general so that an individual is not esteemed according to his personal work, but his social position. America is today the only civilized country where no restraint is placed on the pleasure of working, either through antiquated regulations or through the rights of privileged classes."

We can all help keep in vogue American ideals as pictured by Mr. Piefke if we put our shoulder to the wheel and prevent the enactment of health insurance laws and other Bolsheviki doctrine that certain dreamers are trying to foster upon us.

*Committee on Social or Health Insurance of
the Chicago Medical Society,*

ED. H. OCHSNER,
GEO. APFELBACH,
J. R. BALLINGER, *Secretary*,
C. J. WHALEN, *Chairman*.

*Committee on Social or Health Insurance of
the Illinois State Medical Society,*

ED. H. OCHSNER,
GEO. APFELBACH,
C. A. HERCULES,
JOS. FAIRHALL,
J. R. BALLINGER,
E. W. FIEGENBAUM,
C. J. WHALEN, *Chairman*,
W. D. CHAPMAN, *Secretary*.

FAILURE OF GERMAN HEALTH INSURANCE—A WAR REVELATION

An article written by Frederick L. Hoffman, third vice-president of the Prudential Insurance Company, and read before the annual meeting of Life Insurance Presidents, is one of the best things we have read relative to health insurance. We do not see how anyone can read this article and not have serious doubts as to the advisability of compulsory health insurance, no matter how strong an advocate of health insurance he had previously been.

We have not space to reproduce the entire article, but the following extracts are quoted from it:

The primary purpose of the establishment of compulsory social insurance in Germany was to hinder the rise, curtail the powers, and ultimately destroy the Socialistic movement, chiefly as represented by the political activities of the Social Democratic party. It was conceived by the imperial regime as a paramount necessity to stabilize and perpetuate the imperial throne and as a condition precedent to the secret projects of the military powers for world conquest and imperial aggrandizement.

The foundation document of German social insurance was signed by Emperor William I on November 17, 1881. The armistice terminating the world war was signed by a Socialist in behalf of the German people on November 11, 1918. The paternalistic system had been tried and been found wanting.

All compulsory social insurance rests upon profound misconceptions of life and labor in a democracy, for it involves the establishment of a permanent class distinction in precisely the same pernicious manner as

class distinctions were established in England under the Poor Law of 1601.

Social insurance in Germany was never more than a carefully designed but most insidious form of poor relief, or supplementary grants in aid, required to amplify insufficient incomes, or offset unwholesome or otherwise detrimental environmental conditions.

The system was a failure even in the direction in which it had been anticipated it would be most successful. The amounts paid out in the form of relief were, broadly speaking, inadequate or insufficient to provide the workman concerned or his family with the required degree of economic security common to the people of this country. The medical attendance was far from being anywhere near to the high degree of intrinsic medical skill, in conformity to the remarkable progress in modern medicine and surgery. The low average earnings of most of the members of the medical profession in Germany were out of all proportion to their social and professional status. They, indeed, perhaps more than any other element of the German people, deliberately exchanged a condition of relative freedom for absolute bondage. The so-called panel system resulted in the entrenchment of mediocrity in medical service by discouraging the fullest exercise of unusual skill. Another and truly lamentable result of German compulsory sickness insurance has been to bring into existence a vast amount of alleged illness, or an exaggeration of the relative importance of minor ailments, involving enormous and largely unnecessary disbursements, followed in certain industries at least by serious difficulties in international competition. No wonder that, with a full understanding of the fragile fabric erected with such consummate skill in false pretense and elaborate deception, the late Imperial German Government should have initiated and supported with an abundance of means a subtle propaganda for the organization of corresponding institutions or methods in all the industrial countries with which her people were in constant and often strenuous international competition.

In the words of William A. Brend, Great Britain, author of a standard treatise on Health and the State, written largely with reference to the pernicious effects of national health insurance, observes that:

"The National Health Insurance Act is the most ambitious piece of public health legislation ever carried through in this country. No previous measure has directly affected so large a number of persons, involved so great a cost, made such demands upon administration, or been introduced with such lavish promises of benefit to follow, and no previous measure has ever failed so signally in its primary object."

What is true of England is even more true of Germany. Compulsory health insurance did not improve the health of the working portion of the community, nor did it materially raise the standard of public health. All the more conspicuous and gratifying results in the improvement of social conditions, the lowering of the death rate, the gradual elimination of preventable

diseases, etc., were secured more effectively in this country and entirely without compulsory insurance, than in Germany or the United Kingdom, in consequence of the establishment of pseudo-insurance institutions ostensibly serving public health purposes.

Prof. Arthur Twining Hadley, of Yale University, who in his treatise on economics as early as 1897, said: "There are many reformers who are anxious that other countries should follow the example of Germany. But the experiment has not progressed far enough to pass judgment on its success. In many respects the gain to the public from a system of this kind is more apparent than real. The payments to the insurance funds must chiefly, if not wholly, come out of wages. Even though they may be nominally levied on the employer, he is compelled by competition with other employers who are not subject to this levy to reduce in corresponding degree the revenues which he pays." As high an authority as Prof. Tausney in his *Economics*, concedes that: "The outcome is likely to be that the (compulsory) insurance charges will ultimately come out of the workman's own earnings. This will take place and not necessarily by any process of direct reductions in wages, but more probably in progressive countries like Germany and England, by a failure of wages to advance as much as they would otherwise do."

For to the American propaganda for compulsory health insurance applies with entire truth the dictum that it was "made in Germany" and sustained by German interests, governmental or otherwise, concerned with its universal adoption in the United States. While thoroughly condemned by Mr. Samuel Gompers, President of the American Federation of Labor, and not approved by the American medical profession, nor endorsed by American business interests, this alleged panacea of social reform has been offered to one state after another by the American Association for Labor Legislation in the city of New York, regardless of all the evidence that the system is neither needed nor wanted by the mass of American wage earners and their dependents. In a manner thoroughly undemocratic and opposed to the first principles of a representative form of government, this association and individuals allied to it continue to flood the country with misleading assertions, with cleverly disguised fallacies, supported by the wrongful use of names of men of authority, whose opinions at best but represent merely a desire to support any measure or means whereby it is plain the social condition of the people can be improved.

All of the so-called evidence in favor of social insurance has been derived chiefly from official sources with a deliberate disregard of the truth readily available, proving conclusively the disastrous consequences of the German system upon the mind, the life and the labor of the German people. It would be quite impossible within the limitations of time to do justice to this aspect of the present discussion and what follows is of necessity restricted to compulsory health

insurance, but with the evidence practically down to date.

7. The condition of the medical profession throughout Germany has not been materially improved, but quite to the contrary the ethical standards have been perceptibly lowered, attaining in some communities to the proportions of a positive public scandal. The better element has been discouraged by the opportunities extended to the more unscrupulous to encourage malingering and fraud and widespread imposition upon the funds. Instead of harmonious relations prevailing after thirty years of experience between the medical associations and the sickness insurance funds, quite to the contrary there has been continuous warfare, best illustrated by the frequency of so-called "doctors' strikes." A vast amount of previous time and thought is wasted upon needless treatment for trivial or imaginary complaints, while treatment for serious afflictions is often grossly inadequate to the purpose of a cure.

14. After all, the most lamentable consequence of social insurance in Germany has been the measurable lowering of the social and individual morality of the German people. The system in every direction has fostered dishonesty, deception and dissimulation. Imposition upon the funds, the drawing of sick pay during periods of unemployment as the basis of certificates of illness wrongfully issued by attending physicians, had become the rule rather than the exception throughout Germany at the outbreak of the war.

Numerous investigations made by impartial inquiry reveal the widespread practice of malingering, frequently attaining to half the proportion of all the sick claims, chiefly made for short periods of time and involving in the aggregate enormous burdens upon German industry. Lax social morality in this direction is reflected also in the high rate of suicide, in the relative frequency of suicide among children, in deplorable conditions of sex morality and lamentable shortcomings in housing accommodation.

Every voter should read this article and particularly should every doctor have a copy, which, no doubt, can be secured by writing to the Insurance Economics Society of America, 429 Majestic building, Detroit, Mich.

AN APPEAL TO THE DOCTORS

In the present epidemic, it has been proven beyond a doubt that the Scott County Medical Society has less influence than the West End Ladies' Sewing Club. Not only were the doctors ignored, but in many cases their services were ridiculed.

Suppose we had an organization which could have said to the city mayor, if you cannot adopt our advice in handling this epidemic, all of us will refuse to make any medical calls; in four

hours' time the authorities would have been on their knees to us and the care of the public health would have been absolutely in the hands of the men competent to handle it. Why is it that an organization consisting of seventy able-bodied physicians gets no recognition in an emergency which above all else needs the training the doctors spend from four to six years in getting? When a financial crisis is on, does the city go to the butcher, baker, or candlestick maker, or does it call in the bankers and abide by their advice? When new laws are necessary, does the city ask the retail merchants' association to tell them how to draft new laws, or does it go to the bar association?

Why is it that it costs a family more to call a plumber than it does to call a doctor, and why is it that you can get a doctor to drive to Walcott and make a professional call cheaper than you can hire a taxi to go there? Why is it that the doctor is the last man to be paid, and the first man to be called whenever charity is to be dispensed? Why is it that the government pays labor double prices and expects the doctors to donate their services, not only to donate but to neglect their paying business to do free service?

Why is it that political, financial and industrial influence of the medical society is practically nothing?

And why is it that while all prices have advanced two hundred per cent in the last ten years, medical services are, if anything, cheaper? *These are a few facts that ought to make the doctors sit up and take notice.*

The answer is so simple that a child can guess it. Every line of labor and art has organized, has recognized the necessity of *united effort*. Only the medical fraternity has no organization worthy of the name. The plumber and carpenter has recognized the great truth, that in *union there is strength*.

It took the allies four years to get into a *united body*, and for four years, just like the medical fraternity, they were beaten to a frazzle. After the allies recognized the value of organized effort it took four months to gain their object.

For twenty years the medical fraternity has been "beaten to a frazzle" by their communities till their power is held as cheap as this last influenza scare proves. In four months the medical fraternity, too, could win their war, and put

themselves back into the prominence where once the doctor stood.

Can we learn from the unions? Is it not a fact that Mr. Gompers today, next to President Wilson, is the most powerful man in America, and why? Is there any union in Davenport less effective than our society, and is there any union anywhere which has greater intellectual ability and less actual influence?

You cannot find any seventy men in Davenport who do not exercise more power politically than the seventy doctors, just because you can not find seventy men anywhere of normal intelligence who would not organize if they wanted something.

NOW THE ANSWER: Quit arguing separately, argue together. Quit quarreling with one another, quarrel with the public of this city until the city realizes what we are. In an emergency like the past one, if two or more doctors were delegated to speak with authority from the medical fraternity, their voices would be heard. *Self-interest*, if nothing else, ought to make any group of men *united*.

DIAGNOSIS: General debility.

PROGNOSIS: Complete recovery (if directions are followed).

TREATMENT: *Get together and form a union, a real union.*

ROBERT E. JAMESON,
Secretary Scott County (Iowa) Medical Society.

Public Health

INFLUENZA DURING JANUARY

While influenza and influenza-pneumonia are being reported in all sections of the state, epidemics of very considerable magnitude no longer prevail. Jacksonville, Jerseyville, Mt. Vernon and several other communities are now suffering a third epidemic but the type of disease seems to be milder and the death rate considerably lower than during the months of October, November and December.

The impression that children were not susceptible to the disease, which became prevalent during the first epidemic, was not sustained during the second epidemic nor is it at the present time. In fact in a number of communities the children affected by the disease were largely in the majority. Doubt is also raised as to the observation made earlier in the year that tuberculosis individuals are immune from influenza. More recent reports seem to indicate that

while consumptives are not particularly susceptible, their immunity has probably been over-rated. Statistics are not yet available to justify an intelligent opinion as to whether or not the influenza epidemic will materially increase the incidence of tuberculosis. Such data will probably not be available for several months.

COUNTER PRESCRIBING DECREASING

During January the Division of Social Hygiene of the State Department of Public Health transmitted copies of the rules and regulations for the control of venereal diseases to six thousand pharmacists in the state. The rules were accompanied by a letter urging co-operation on the part of druggists and the abandonment of counter prescribing and the sale of nostrums for venereal diseases. The results of this appeal have been singularly gratifying, a large number of pharmacists agreeing to refer all such cases to physicians for treatment.

A large number of druggists, in replying to the Division, declared that a serious situation would develop from the cessation of counter prescribing on account of the fact that a large percentage of physicians refused to treat patients suffering from venereal diseases. In some communities the action taken by druggists at the request of the Department of Health removed the only means through which infected residents could obtain remedies of any kind.

The State Department of Health is making a strong appeal to all physicians to co-operate with the Federal and State Governments in its warfare against venereal infection by accepting cases of this type, particularly since the druggists have manifested a willingness in so many instances to discontinue a practice which has always been obnoxious to the medical profession.

If treatment cannot be secured through local physicians for these unfortunate persons it will be necessary to make provision through dispensaries or otherwise by the state and federal agencies.

NEW TUBERCULOSIS CIRCULAR

A completely new circular on the cause, prevention and treatment of pulmonary tuberculosis has just been issued by the State Department of Public Health and is ready for distribution. This circular is intended for the layman and contains, in addition to general information on the cause, prevention and treatment of the disease, a summary of the rules and regulations of the Department for the control of tuberculosis and a directory of public and private sanatoria and public tuberculosis dispensaries.

One chapter devoted to the care of the tuberculosis patient will be found particularly valuable to physicians inasmuch as it contains all of the essential facts which should guide the patient's everyday life.

Copy of this circular in any reasonable quantity will be furnished without cost upon application to the Director of the Department of Public Health, Springfield, Illinois.

EDUCATIONAL WORK IN SOCIAL HYGIENE.

The Division of Social Hygiene of the State Department of Public Health has announced a series of lectures to be delivered under the auspices of the various military companies throughout the State. These lectures will be open to the general public.

A series of lectures is also being prepared to be delivered to audiences of women to be illustrated by a motion picture film, "The End of the Road." The Division of Social Hygiene has ready for distribution six sets of educational pamphlets which will be supplied to physicians, health officers or other interested persons, without cost. One of these sets, made up of five pamphlets, is written for young men. A set of six pamphlets is designed for public officers and business men. A set of three pamphlets has been prepared for boys and a set of three for girls and young women. Another set of four pamphlets is designed primarily for parents, while a series of six pamphlets is designed for teachers and educators.

LABORATORY WORK FOR JANUARY

The Division of Diagnostic Laboratories of the State Department of Public Health reports a remarkable increase in requests for containers for sputum specimens. This increase is attributed partly to the disturbance of the respiratory organs incidental to the influenza-pneumonia epidemic. The steady increase in tuberculosis throughout the State, however, has caused more examinations of sputum from year to year.

The recent announcement that Wasserman tests would be made by the State laboratories without cost has been responsible for the receipt of very much larger numbers of specimens of this kind.

COMMUNICABLE DISEASES IN ILLINOIS

The incidence of communicable diseases in the state has remained relatively low throughout the past three months and was perhaps lower for the month of January this year than for the month during any years past. Smallpox cases in considerable numbers were reported at Schram City, Elgin, Peoria, Pekin and Rock Island with a few cases at Olney and Salem. There was but one small epidemic of scarlet fever in the state and but one outbreak of disease which assumed serious proportions. Only seven cases of poliomyelitis were reported in the State, six in Chicago and one at Eldorado.

GOVERNOR ENDORSES HOUSE CODE

In his formal address to the General Assembly, Governor Lowden pointed out the necessity of the adoption of a housing code for the State of Illinois and it is stated that a bill for a housing law will be introduced in the near future by Senator H. C. Kessinger of Aurora. In his appeal for a housing code Governor Lowden laid special stress upon its importance from a public health standpoint, calling attention to the fact that large public expenditures are now being made for the treatment and cure of diseases for which unsanitary housing may be regarded as to a certain extent responsible.

IMPORTANT DECISION AS TO COUNTY SANITARIA

The Supreme Court of Illinois has recently handed down a decision in the case of *The People ex rel v. Wabash Railway Company*, in which it is held that the favorable vote of the people for the establishment of a county tuberculosis sanitarium under the so-called Glackin Law does not provide the funds for the establishment of such an institution. The case arises out of an effort on the part of the county authorities of Morgan County to collect taxes for sanitarium purposes from the Wabash Railway Company. Under the Glackin Law the people may vote on the establishment of a county tuberculosis sanitarium for which there may be levied a special tax of not to exceed three mills on the dollar. The constitution of the State of Illinois provides a limit of taxation at seventy-five cents on the hundred dollars and it is necessary to take a special vote of the people to assess a tax in excess of that amount. In substance the Supreme Court contends that it is not within the power of the General Assembly to pass a law nullifying any of the provisions of the constitutions and that if the sanitarium tax of three mills will cause the total county tax to exceed the constitutional limit, it is necessary to submit both propositions to the people. That is, it is necessary for the people to vote to establish the sanitarium and then it becomes necessary for the people to vote on the proposition of levying a tax in excess of the constitutional limit.

Incidentally, women may vote on the proposition of establishing the sanitarium, but are not permitted to vote on the constitutional provision of levying an excess tax.

PROPOSED NEW LEGISLATION

Among the measures relative to public health that are being considered for submission to the present General Assembly are three which will attract general interest. One of these is a proposed measure providing for medical inspection of schools and a second provides for the physical education of children and carries with it a medical inspection provision. The third measure is one for the establishment of a full-time medical health officer appointed under Civil Service in each county in the State having a reasonable population.

It is very likely that a large number of bills for laws affecting public health and social conditions will be introduced at this session as a result of the tremendously awakened social activities incidental to the war.

SANITARY SURVEY OF EAST ST. LOUIS

The Division of Surveys and Rural Hygiene of the State Department of Public Health is preparing to undertake the sanitary survey of the city of East St. Louis in conjunction with the general program of civic development being carried out by the War Civics Committee. This sanitary survey will include

a thorough investigation of water supply, sewer system, and disposal of wastes, the control of communicable diseases, morbidity and mortality statistics, sanitary conditions of schools and public places; soil pollution, milk supply and public health administration.

In the general plan which the War Civics Committee is carrying out in East St. Louis, there is already going forward a survey covering housing industries and recreation.

Society Proceedings

COOK COUNTY

CHICAGO MEDICAL SOCIETY.

Regular Meeting, January 8, 1919.

1. The Immediate Surgical Management of Appendicitis in Military Hospitals, with a Report of Some Observations Made at Camp Pike Base Hospital—Lieut.-Col. Hugh McKenna.

Discussion—D. J. Davis,

E. Wyllys Andrews,

L. L. McArthur.

2. Work With the Children's Bureau, American Red Cross, in France—Clifford G. Grulee.

Regular Meeting, January 15, 1919.

1. Acriflavine—Its Value in Specific Urethritis—B. C. Corbus.

General Discussion.

2. Gunshot Injuries to the Joints—Lieut.-Col. R. B. Osgood, M. C., Washington, D. C.

Discussion—A. J. Ochsner,

C. W. Hopkins.

Regular Meeting, January 22, 1919.

Joint meeting of the Chicago Medical and the Chicago Neurological Societies.

1. War Neuroses—Hugh T. Patrick.
2. Report of Neuroses in Soldiers With Presentation of Cases—Peter Bassoe.
3. Some Lessons in Psychiatry Taught by the War—H. Douglas Singer.

Discussion will be opened by George W. Hall.

Regular Meeting, January 29, 1919.

Red Cross Night.

1. Red Cross. A Year's Accomplishments. Activities of Chicago Chapter—Marquis Eaton, Chairman Chicago Chapter.
2. Educational Propaganda. Work being done and to be done in Teaching First Aid and Home Nursing with Care of the Sick, both Army and Civilian, with a Possible Solution our Nursing Problems—Henry W. Gentles, Chairman, First Aid Division.

Discussion—C. A. Hercules.

CHICAGO OPHTHALMOLOGICAL SOCIETY.

A clinical meeting was held May 13, 1918, with the president, Dr. Heman H. Brown, in the chair.

DR. THOMAS FAITH reported the following case: D. S., Italian laborer, aged 38. This patient, whom some of the members had previously seen, was injured by a foreign body in 1915. He was under the care of an ophthalmologist for about two months and was discharged as recovered, or, rather out of danger, as the eye was quiet. However, he noticed that his vision was gradually failing and on July 24, 1915, he applied to the eye clinic at the Illinois Eye and Ear Infirmary for treatment. He saw Dr. Robert Von der Heydt, who found vision in the right eye 20/30; in the left eye 15/200. A diagnosis was made of a piece of steel in the vitreous of the left eye. For some reason the patient did not return to the infirmary and received no further attention until Jan. 23, 1918, when he was sent to the speaker on account of a slight injury to the left eye, caused by being struck with a piece of ice. There was no abrasion of either the lid or eyeball, but a contusion of the upper lid and an ecchymosis of the conjunctiva. The patient complained of increased cloudiness of vision, which at this time was light perception only, his pupil was fixed and would not dilate with cocain and homatropin and his tension was 48 mm. He did not complain of pain and there was no ciliary tenderness. He was immediately sent to the hospital and was put upon hot applications, dionin 5 per cent, and salicylate of soda gr. xlxxx per day. After a few days of this treatment it was decided to do an iridectomy, thinking the patient had a secondary glaucoma due to annular posterior synechia, and as he had been told by the patient that the gentleman who first saw him had radiographs made and assured him there was no body in the eye. The above information was obtained after he had done the iridectomy, and it had not relieved the tension as he had anticipated. Accordingly, x-ray and Sweet localization showed a foreign body in the anterior segment of the eye.

He showed this case at the March meeting of the society and two days later he enucleated the eye. On March 29th, the patient complained of pain in the right side of the head, and there was some injection of the right eye, but not pronounced and not deep. There was no tenderness in the ciliary region and no pain in the eye; pupil dilated fairly well with cocain and homatropin. There were some deposits on Descemet's membrane; vitreous cloudy; vision 20/40 with correcting lens. Patient was given salicylates gr. xxxx, inunctions of mercury, gr. xx per diem. Blood count at this time showed a marked increase in the lymphocytes. The treatment was continued, both salicylates and inunctions being increased in amount. The patient had very bad looking teeth, namely, they were covered with tartar, and the speaker advised that they be scaled so that the gums and teeth could be kept clean. This was done, and it seemed to have a marked influence upon the eye condition, as improvement was rapid afterwards. The vision has never gone below 20/60 and it is now 20/20 with correction. The deposits are disappearing from Descemet's membrane, and the patient is going to have a good eye, a rare result after sympathetic disease.

In looking over the literature, the speaker has found that Jampolsky in 1915 reported eight cases of sympathetic ophthalmia which occurred in the Fuchs clinic after enucleation of the injured eye. In one of these the eye was enucleated 18 days after the injury, and the sympathetic disease began 12 days later. The longest period after enucleation in which sympathetic disease began was 38 days, twenty-nine days having elapsed between the time of injury and enucleation.

In addition 33 cases are gathered from the literature. The summary of ultimate results in these cases fully supports the conclusion of the Committee of the Ophthalmological Society of the United Kingdom, that after such removal of the injured eye, the prognosis is much better than where the sympathetic disease has appeared before removal of the injured eye. Of the whole group, 60 per cent recovered good vision.

DISCUSSION

DR. M. H. LEBENSOHN stated that he had had a number of cases of sympathetic ophthalmia. One he recalled in particular was a boy six or seven years old, who was brought to the Illinois Charitable Eye and Ear Infirmary with a history that the boy's left eye was hurt about four and one-half weeks ago in playing with a brother. How the accident happened the mother could not tell, only she noticed that he could not see with that eye. There was a small scar in the lower border of the cornea. The eye was not red or painful at any time. On examination he found not only was the left eye (the injured eye) blind, but there was a fully developed sympathetic ophthalmia in the right eye. The following day the left eye was enucleated, and half of a pearl button was found in the vitreous. The enucleation did not stop the progress of the sympathetic eye, and the boy in the course of about three or four months became totally blind.

The only thing that the speaker found during the treatment of this case and several other cases he had treated that gave even temporary relief, or that seemed to stay the progress of the disease for a time was injections of cyanide of mercury, 1/1000 injected both in the orbit and in the subconjunctiva. He advised the members to try this agent in addition to other means of treatment.

DR. MICHAEL GOLDENBERG, in referring to the case of Dr. Faith, stated that possibly better results were obtained following enucleation previous to the onset of the sympathetic ophthalmia. He had a case on his hands now that he had seen off and on for seven or eight years. A little girl in returning home from school passed near a bonfire, some boys threw bullets into the fire, causing an explosion. A piece of shell entered her eye. She was brought to the Infirmary in a few hours thereafter, and within 24 or 48 hours the eye was enucleated. About 16 or 18 days later sympathetic ophthalmia developed in the other eye. For a period of six or seven years she had had 12 or 18 attacks of sympathetic ophthalmia. These attacks had varied in their severity. At times, her vision in that eye became absolutely nil. Even perception to light was gone. She had had on three or four occasions optic neuritis. It was a question whether this was sympathetic ophthalmia. Every sort of examination, test, X-ray, every laboratory method known, had been tried to ascertain whether any other factor could have influenced this condition, but he had not been able to find out anything definite. The vitreous humor was filled with an exudate to such an extent that the speaker could not get the light reflex at the time, and in the course of a few weeks or months it would clear up, so that he could not find any evidences of the previous condition. He had seen the patient within the last two months, and with correction, which was rather high, three or four dioptres plus, she got 20/25 vision. She had come back with attacks so frequently that he would not be surprised to see her with no vision at any time.

DR. HEMAN H. BROWN asked whether in these various attacks the treatment was uniform.

DR. GOLDENBERG replied that at first he tried treatment similar to that mentioned by Dr. Faith. He gave the salicylates and mercury; he also gave potassium iodid, prescribed sweats and purges, then subconjunctival injections, and even tuberculin. A tuberculin test was made, and the treatment that gave the best results was inunctions of mercury. He excluded very carefully luetic infection. Her sinuses were X-rayed, and her teeth and tonsils were carefully examined.

DR. ROBERT H. BUCK stated that in connection with these inflammatory cases due to local infections, he might cite a case that came into the office recently. This patient had had recurrent attacks of iritis. At the time he came in he had had an attack of iritis for two weeks. On examination it was found that the patient had a bridge on one side of his mouth, and one tooth in that bridge was abscessed. Following extraction of the tooth the iritis cleared up in two or three days.

DR. THOMAS FAITH stated that most of the severe cases of sympathetic ophthalmia were in children. He did not believe that we got any such results in children as in adults. He did not recall ever seeing a case in which normal vision was recovered, although he knew of a number of cases reported. Most of the cases he had seen had been in children.

If one studied all these cases of iritis, he could not help but be impressed with the fact that many of them had two or three different elements in helping to cause the trouble. One saw so much in the literature these days regarding the influence of focal infection in producing uveitis, that one was likely to conclude that he had to completely rearrange his percentages. These cases in Fuchs' clinic had been studied carefully, and whether they were all adults or children, he was not able to say.

The Committee of the United Kingdom, that had gone over the subject very thoroughly had come to the conclusion that after the removal of the injured eye the prognosis was much better than where the sympathetic disease had appeared before the removal of the injured eye. Certainly, we could not promise patients that we could save them from having sympathetic ophthalmia. We could promise them, in all probability, that the sympathetic disease, should it occur, would be less severe than if the eye was allowed to remain.

A CASE OF ECTOPIA LENTIS WITH FAMILY HISTORY.

Dr. William K. Spiece reported the following case:

H. C., aged 7. His school teacher noticed his poor vision and sent him to the school physician. The physician noticing the iridodonesis referred the boy to the speaker as an interesting eye case.

On examination his vision was found to be R. E. 5/100; L. E. 5/100.

Iridodonesis was very noticeable, especially following movements of the eyeball. The anterior chambers were deep, more so on the aphakic sides. With oblique illumination, both lenses were seen to be dislocated upward and outward, leaving a small crescentic aphakic area downward and inward. No zonular fibers were to be seen and the lenses were clear. Following the use of atropin a satisfactory retinoscopic examination of the aphakic area was made, but not of the phakic portion.

Glasses improved his vision as follows:

R. E. $+10.00$ D $+2.00$ D. c. a. $90^\circ = 20/200$.

L. E. $+13.00$ D $+1.00$ D. c. a. $90^\circ = 20/100$.

The nasal side of each fundus could be seen fairly well. Aside from the right disc appearing somewhat pale, they were negative.

About two weeks after the use of the cycloplegic

the pupils were again normal in size. His vision with glasses was then: R. E. 20/200; L. E. 20/100.

His mother presented a pair of spectacles which she said had been prescribed by a physician about a year ago, but they had not been satisfactory. They were: O. D. and O. T. — 1.50 D.

His mother said that her eyes were similar to her son's, and on examination such was found to be the case. She also reported the case of a sister whose eyes were in a similar condition.

Mrs. Albert C. (the mother), aged 38. On examination iridodonesis was noticed following ocular movements, and the cover test showed an exophoria of 3 mm. The vision is R. E. 10/65; L. E. 10/200.

Following the use of hemotropin the lens of the right eye was seen to be dislocated upward and outward. The left lens was in position. After retinoscopic examination glasses improved her vision as follows: R. E. $+5.00$ D $= 20/50$; L. E. $+3.00$ D $= +.50$ c. a. $90^\circ = 20/50-1$.

The examination of the left fundus showed a disseminated choroiditis with an atrophic area just above and to the nasal side of the disc which, on first appearance suggested a movable lens.

Elsie C. (sister), aged 9. R. E. 20/32; L. E. 20/65 — 1. Ophthalmoscopic examination of the left eye revealed a bleb or vesicle about 2 mm. in diameter, centrally located on the posterior surface of the lens.

Mrs. G., aged 27 (the aunt; mother's sister). Examination reported by Dr. E. A. Westcott, Manistique, Michigan. Left eye, divergent squint about 30° . Both anterior chambers deep. Both irides tremulous. O. D. 8.100 with $+8.00$ D $= 20/60$; O. T. 2/100, not improved by glasses. On dilating the pupils one saw with the ophthalmoscope the upper outer edge of each lens. The right lens was transparent, and in the left there was beginning cataract. Could only see fundus past the edge of the opaque lens. She had a son, aged 6, whose eyes were in a similar condition.

Genealogy of H. C.:

Six (6) children, 2 brothers and 3 sisters.

Brother, aged 12, V. R. and L. 20/20 Hm .25.

Brother, aged 10, V. R. and L. 20/20 Hm .25.

Sister, aged 9, V. R. 20/32, V. L. 20/65 (L. Post. Polar vesicle).

Sister, aged 7, V. R. and L. 5/100.

Sister, aged 5, V. R. 20/30; L. 20/50 neg.

Sister, aged $1\frac{1}{2}$, negative.

H's father, eyes good.

H's mother, eyes poor (same condition, unilateral).

H's maternal uncles (3), aged 36, living, eyes good; aged 20, dead, eyes poor; aged 4 mo., dead; Mrs. C., 38.

H's maternal aunts (4, aged 33, living, eyes good; Mrs. B., aged 27, living, eyes poor (son, aged 6, poor eyes); aged 20, living, eyes good; aged 6 mo., dead.

H's maternal grandfather, aged 60, living, eyes good (has no brothers or sisters).

H's maternal grandmother, aged 52, dead, eyes good (one brother only, good eyes).

DISCUSSION

DR. FREDERICK D. VREELAND mentioned a case that Dr. Joseph Beck reported at the Cook County Hospital. In this case the lens was dislocated, and he described the other eye as having the lens outside of the iris against the cornea and the lens entirely clear. Dr. Vreeland did not recall having seen such a case, neither did Dr. Darling.

DR. LEBENSOHN thought Dr. Woodruff had operated on a case of this sort at the Infirmary some three or four years ago in which he delivered the lens. In this case the condition was congenital. The patient was 11 or 12 years of age.

DR. VREELAND stated that this patient to whom he had referred had been under the observation of Dr. Beck for two and a half years.

DR. ROBERT H. BUCK recalled a case that came into the Infirmary about a year ago in which there was a dislocation of both lenses, which were floating free in the vitreous. As the patient moved the eyes, the lenses would come up before the pupil and then drop back again, so that one could just see the upper edges of the lenses.

DR. WILLIAM K. SPIECE, in speaking of the cause of this developmental defect, stated that in reading the literature he found that some of the writers had endeavored to put forth ideas as to the cause. Two of them assumed somewhat the old woman's idea that the cause for all these defects was similar to that of birthmarks. One writer in the Wisconsin Medical Journal in reporting a series of cases of ectopia lentis in a large family, gave the father's idea as to the cause of it and it was simply this: in his earlier years, when he first got married, he was quite poor, and the mother had to do the work, the drudgery of the household, and for that reason it left an indelible impress upon the children. This explanation of the cause did not appeal to the speaker very much, any more than the old woman's idea of the cause, birthmark.

Several other writers had advanced ideas along the line of eugenics which appealed to him. Whenever any one began to discuss eugenics they referred to Mendel's law. Mendel was a naturalist. He did his work principally in the garden. He was ingenious and conducted a series of experiments with different vegetables unselected and worked out the different characteristics of plants, and from these experiments he developed the so-called Mendel's law. According to Mendel, we have the traits, abnormal characteristics and recessive characteristics, and one might say in this instance a normal eye would be the dominant characteristic, and the abnormal eye would be the recessive. Mendel laid down the law that the recessive trait bore the proportion of one to four to the dominant. Three times normal would develop the dominant characteristics, and once a recessive, and in all these cases that had been shown the proportion came close to that, about one to four.

One or two other writers stated that this never occurred unilaterally. But here was one case where it did occur unilaterally. Parsons in his pathology had said it occurred unilaterally, and cited such a case. The sister had a posterior polar vesicle which was the same type. However, it had not progressed so far as in the other cases, but it was undoubtedly of the same type. The trouble was with the development of the zonular fibers, the suspensory ligament of the lens. There was no trace of any zonular fibers, and the speaker thought that this case was of the same type as in the mother, the boy, the aunt and cousin. Then possibly one thing more might be said, namely, what were we going to do for it? Most of the writers contend that if there be useful vision it was better to leave them alone. If their vision was very poor, some authors recommended needling.

DR. MICHAEL GOLDENBERG spoke as to what should be done for these cases, saying that some maintained that vision was not improved by operative procedure, and further that the function of accommodation was lost by this interference. He was firmly convinced that given a case not possessing useful vision, by which he meant 20/100 or better, we should resort to dissection of the lens. He felt sure that a majority of these cases would show an improvement in vision in time. He had had a number of such cases that justified such a deduction.

With reference to the development of vision, he reported the case of a young man who had been under his observation

for about ten years. When he first examined him his left eye disclosed a marked choroiditis, persistent pupillary membrane, and coloboma of the iris, with no vision. In the right eye the fundus was negative, with 21/100 vision, improved to 20/50 with glasses. Today the patient had better than 20/20 vision in the right eye, and no improvement in the left. He was now one of the leading professional baseball players in the big league.

He recalled the case of a young lady who was now 28 years of age. She was under the care of the late Dr. Beard some twenty odd years ago, who at that time performed an optical iridectomy in each eye, but did not touch the lenses. He saw the young lady first when she was 23 years of age; she had the mentality and facial expression of a child of 12 or 14, and would sit on the floor and play with the children; she paid no attention to her appearance, and did not seem to take any interest in things expected of one of her age. Her vision at that time was counting of fingers. Today she had 22/100 in each eye and was able to come down town all alone. Her appearance, her mentality, and her interest in things about her were most gratifying.

DR. ROBERT H. BUCK reported the case of a child that was brought to the Infirmary when six months of age. The buphthalmos was pronounced. Both corneas were hazy. The child seemed to notice bright things. If one held a bunch of keys she would reach for them. On account of the condition seemingly progressing and being likely to result in total blindness, both eyes were trephined. The result was gratifying, in that the cornea cleared up in a few weeks. At present she was 18 months of age, could walk around the room, and avoid striking the furniture, or she would approach a person when called. He did not take the tension at the time of operation, and since then he had not felt justified in anesthetizing her to get the tension, so it had not been done. So far as one could tell from external examination, the eyes seemed clear and patient seemed to be developing more vision as time went on. He did not know exactly what the diameter of the cornea was at the time he operated, but it was his impression that the cornea in each eye was getting larger within the last three or four months.

PERIPHERAL IRIDECTOMY COMBINED WITH SCLERAL TREPHINING.

DR. M. H. LEBENSOHN stated that in reporting this case he had nothing especially new to offer, excepting the road peripheral iridectomy combined with scleral trephining which he considered a more desirable and satisfactory operation, and was equally useful in acute and chronic glaucoma. He had operated by this method on five patients; on four, one each eye, and on this patient whom he was presenting tonight on both eyes. Mrs. E. B., aged 55, entered the infirmary February 10, 1918, with a history of progressive failing vision in both eyes for about a year. The tension of the right eye by a Schiotz tonometer was 80; left eye 60. The corneae were steamy, and the anterior chambers very shallow, and pupils dilated. The fundi could not be seen. Vision in the right eye was 22/100; in the left eye light perception only. The vision gradually improved after the operation and was now for the right eye 20/50 without any correcting lenses, and about 21/120 in the left. The tension taken repeatedly was 21 in the right eye and 18 in the left. He had had the same favorable results in the other four patients. Dr. Elliott, who popularized the operation of trephining for glaucoma, did not advise iridectomy excepting to cut off the prolapsed iris. It was known that in chronic glaucoma especially, many times the tension remains down for a short time, but it would rise again and necessitate another oper-

ation, while if one made a broad iridectomy the tension would remain down permanently and the danger of late infection was not increased because the scleral wound was not any longer than in a simple trephining. Hence, whenever a scleral trephining was indicated in glaucoma, a broad iridectomy should be done at the same time. It was much safer than an iridectomy ordinarily performed, as there was no danger of injuring the lens.

DR. LEBENSOLN, in discussing the case of Dr. Buck, stated that he had resorted to scleral trephining in a child a year and a half old. The baby was brought to the infirmary at the age of seven weeks with congenital cataracts in both eyes. There were repeated needlings in both eyes. She developed buphthalmos in the right eye, and tension was 58. He did a scleral trephining six years ago, saw the child for six months after that, and now he saw the child every few months. Tension had remained very good since the operation. The child had useful vision. The other eye was repeatedly needled, and there were no complications.

DISCUSSION

DR. THOMAS FAITH would like to know about the character of the glaucoma, and if the doctor had run across any case in which he was unable to deal with the iris on account of adhesions to the posterior surface of the cornea. He recalled one case of scleral trephining which argued strongly for a broad iridectomy. A woman came to him in 1911 with glaucoma in both eyes. He did double scleral trephining. In one eye he got a good sized opening in the iris. It was a nice peripheral iridectomy. In the other eye the opening in the iris was smaller and could only be seen when the eye was rotated up. The tension in the eye with a larger peripheral iridectomy was always from six to ten points lower than in the other. The size of the conjunctival bleb was always larger in the one in which the peripheral iridectomy was larger. He had seen that case once in two or three months since 1911. She had preserved her vision, although she had had attacks of violent conjunctivitis in which the pneumococcus was found in the conjunctiva, but she had had no trouble so far as deep infection was concerned.

Referring to the case of Dr. Lebensohn which developed buphthalmos, the speaker was under the impression that buphthalmos was congenital, and he wanted to know why Dr. Lebensohn did not classify this case as one of secondary glaucoma.

DR. ROBERT H. BUCK stated with regard to this case of buphthalmos, he was unable to make an ophthalmoscopic examination, but he could see enough to determine that there was not a cataract in either of these eyes. As to broad iridectomy, he did broad iridectomies in both eyes.

As to Dr. Lebensohn's case, he saw this patient when she first came into the hospital and on examination he found that both corneae were very cloudy. They were now perfectly clear. The iridectomy in the left eye was perfectly clean, that is, there was a pillar to the iris on either side, while in the right eye it seemed the iris had prolapsed into the trephine opening, pulling up the pupil.

With regard to getting a broad iridectomy through a trephine opening and getting a good hold of the iris through the opening, he had used a two millimeter trephine, and in so doing generally found that the iris prolapsed sufficiently so that he could take hold of it, pull it out, and do the trephining quite readily. He had a patient, 24 years of age, with buphthalmos that began in childhood, and at the time he saw her the cornea measured 30 millimeters in diameter and protruded 15 millimeters. The bulging was so great that it was decided to enucleate both eyes because of the intense discomfort, and vision was absolutely nil.

DR. FAITH, in working on one of the advisory examination boards stated that he had seen two cases of buphthalmos in

men brought up for the draft. One of them was a case on which Dr. Patillo did an iridectomy when the boy was 12 or 14 years of age, and as far as Dr. Patillo knew vision had not deteriorated since the iridectomy was done. Both eyes were involved and iridectomized, and the result was a good one, but vision was not good enough for him to be accepted for the draft.

CHICAGO LARYNGOLOGICAL AND OTOLOGICAL SOCIETY.

The regular monthly meeting of the Chicago Laryngological and Otolological Society was held Tuesday evening, May 14th, 1918, at 8:00 o'clock, in the East Room of the Hotel La Salle.

The president, Dr. Frank Allport, in the chair.

DR. ERNEST SACHS, of the Department of Surgery, Washington University Medical School, St. Louis, presented a paper entitled: "The Importance of More Intimate Cooperation Between the Various Specialists Who See Neuro-Surgical Cases."

The modern desire for efficiency as well as the increase of medical knowledge has been a potent factor in the metamorphosis of the physician from a general practitioner to a specialist. As a result, they are growing apart which is unfortunate when they are called upon to see cases which necessitate the intimate cooperation of various specialists, this being particularly true with neuro-surgical cases. The men concerned are the surgeon, the neurologist, the ophthalmologist, the rhinologist and the otologist.

The surgeon does not feel as much at home with a neurological case as with an abdominal case. It was too much to expect that the general surgeon should know the minutiae of neurological diagnosis, and yet he was expected to give such cases as good service as his abdominal cases. Such cases require much time for study, and the surgeon ought to be the one to plan and outline the treatment. A surgeon to do neural surgery successfully ought to have a thorough knowledge of neurology and the physiology of the nervous system. The moment a medical neurologist suspects that a case might be surgical he should get the opinion of an operating neurologist, who will study the case from a somewhat different angle. The sooner the need of exploratory craniotomy is recognized, and the fact that multiple operations give better results than an operation at which all is done at one sitting, the sooner will the entire complexion of the situation be changed. The neurologist must be readier to make a tentative diagnosis of brain tumor in the absence of the time-honored triad of headache, vomiting and choked disc. On having made the tentative diagnosis he should give up the prolonged use of iodid and mercury, which for so many decades has been the favorite form of treatment. The fewest intracranial new growths are due to syphilis, but the idea that syphilis, in a large number of cases, is the cause of the intracranial lesion has led neurologists to give patients specific treatment even if the Wassermann and other serological tests were negative, and to carry it on for several months. The Wassermann may be negative and the patient still have syphilis, but, on the other hand, if the case is syphi-

litic it will respond promptly to antisyphilitic treatment. With iodides and mercury used intensively some improvement ought to be apparent in two to three weeks, and unless there is evidence of such a change other methods should be tried. A choked disc should always be presumptive indication for a decompression operation regardless of the underlying pathological cause. Many cases are allowed to go on the blindness without any attempt being made to relieve them, or the attempt is made too late.

Dr. Sachs had come in contact with the rhinologist in three types of cases: 1. Infections of the sinuses, especially the sphenoid and ethmoid. 2. Trigeminal neuralgia. 3. Pituitary conditions. The optic nerves lie so close to the sphenoid that they may become involved in an inflammatory process, and whether a true choked disc could be produced was an open question. The rhinologist claimed it required weeks to determine whether the eye changes would be relieved by draining the sphenoid, and those weeks of waiting might be the crucial ones in the life of the optic nerve.

Pain in the distribution of a part or all of the fifth nerve is a common symptom associated with sinus disease and if a sinus infection is present that should be first disposed of, but the patient should first have a neurological examination, *preferably by the rhinologist*, to determine if there is any more deep-seated cause for the patient's pain. An intracranial new growth involving the Gasserian ganglion, and a posterior fossa process which involves the root of the fifth nerve prior to its entrance into the ganglion deserve particular attention. If the pain proves to be due to a true tic douloureux, no harm has been done by cleaning up the sinus disease and frequently much benefit may have been derived.

Pituitary conditions, sometimes, are first seen by the rhinologist. In several cases seen by the author polypoid masses removed from the nose were really portions of an adenoma of the pituitary. The slight evidences of pituitary disease have not thus far attracted the attention of medical men as generally as have the moderate involvement of the thyroid.

In view of the uncertainty which he felt still exists regarding the interpretation of the Barany tests, he uses it merely as corroborative evidence. With all other findings negative he never is willing to subject a patient to operation when only the Barany is positive.

The ophthalmologist is so much occupied with the most highly specialized sense organ in the body that he sometimes forgets its intimate connection with the nervous system. We want the ophthalmologist to become more interested in the methods of preventing choked disc from going on to atrophy, and to accept the view that a choked disc, even in the absence of all other symptoms, calls for a decompression operation. The assayer offered the following suggestions:

1. That the surgeon must have had a thorough training in neurology, otology and ophthalmology to enable him to make the diagnosis himself and outline the treatment.

2. That the neurologist conceive of the surgeon as

his partner in diagnosis and call upon him whenever there is the slightest possibility that the case in point may have a surgical aspect.

3. That the rhinologist, ophthalmologist and otologist take a greater interest in the nervous system as a whole rather than in that portion pertaining only to their specialties, and that the first two introduce the ophthalmoscope into their armamentarium.

4. That as neuro-surgical cases present to many borderline problems, a society of which these various specialists belong might do much to bring them all together.

DISCUSSION

DR. CARL BECK, President of the Chicago Surgical Society, was willing to plead guilty right in the beginning, and was glad he was not in neurological surgery any more. About twenty years ago he did a good deal of work in brain surgery and imagined himself a great nerve surgeon, but shortly afterward visited London and saw Horsley's work and realized that he was not fit to be a brain surgeon. He believed the general surgeon should not do both brain surgery and abdominal surgery, for the work of a specialist required a great deal of study, but thought that all who did surgical work should have a general training in surgery so that under given circumstances they would be able to do anything. He agreed with Dr. Sachs that the surgeon who did neurological work should be trained in neurology and that there should be team work among the specialists. He felt that it was impossible to do any work of value except in this way. There should be schools where men could go and receive training in neurological surgery so that experts could be developed who could spread the knowledge and work satisfactorily.

DR. JAMES C. GILL, of the Chicago Neurological Society, was sure the neurologists should keep more in touch with the other specialists, and that there should be early consultations. Operation on the nervous system was often postponed until irreparable damage was done and operation could be of no service. Unfortunately, one could not look into the cranial cavity and always be sure of what pathological condition was present, nor could they always follow the descriptions given in the text books, or what they had learned in a general way in considering symptoms. Neurologists as well as surgeons saw many cases of tumors of the brain in which the three cardinal symptoms,—choked disc, nausea and vomiting were all absent. He cited one such case in which a postmortem showed a glioma involving the left temporal sphenoidal lobe which had produced none of the symptoms which one expected to find in cases of intracranial neoplasm. In epileptiform diseases that required operation this was often delayed because the physician could not make out certain etiological factors, and went on treating the cases medically without benefit when they should be referred to the surgeon. The same was true in many cases of possible hemorrhage. It was his opinion that the work being done by Dr. Sachs and others along this line was of much value and would lead to better cooperation.

DR. J. F. BURKHOLDER, representing the Chicago Ophthalmological Society, was satisfied that the ophthalmologist would have to plead guilty to Dr. Sachs, and thought very few of them were as intimate with brain surgery and brain anatomy as they should be, or as well acquainted with the human body as a whole as was desirable. They were apt to forget that there was anything except the eye, just as some general practitioners were apt to forget that the body had an eye at all. While at one time exclusion was the attitude of the members of the profession toward each other, they were entering a new era and could be made successful by just such suggestions as Dr. Sachs had made. He had always considered it strange that more men did not try to learn the ophthalmoscope. It was one of the easiest instruments to learn and was of great assistance, particularly in cases of choked disc. It did not seem rational to him that choked disc and papillitis should be classified synonymously. Some cases of choked disc were due to intracranial pressure, and there was no question but that Dr. Sachs was right regarding a decompression. When

thinking about decompression or surgical work on the cranium one should remember that choked disc or papillitis had been reported in eighty-three different diseases. One needed to be sure about intracranial complications, but when sure the man who hesitated was lost, for where the nerves enter the eye-hall they are not myelinated as a rule, although myelinization does sometimes take place. The hypotheses regarding the etiology of choked disc were so numerous that it was hard to find one that would be satisfactory to all persons.

DR. JOSEPH C. BECK was pleased to have been somewhat responsible for the presence of the guest of the evening, but thought that in order to fully appreciate Dr. Sachs one must see him at his work. He was particularly interested in his discussion on the indications for decompression, and was only too sorry that he did not know Doctor Sachs at the time he needed him most. He was referring to the loss of his brother, Dr. Rudolph Beck, whom most of the members remembered, and who died in consequence of a brain tumor which was operable but was not diagnosed until it was too late. The boy suffered agonies and some of the best surgeons were consulted, but they were not ready to do a decompression operation. The postmortem examination showed that sooner or later a localized diagnosis would have been made on him and he might have been saved, or the decompression been made, as was indicated in Doctor Sachs' statements.

DR. H. W. LOEB, St. Louis, thought the most important part in the excellent paper of his distinguished fellow townsman was the inference that the brain surgeons and neurological surgeons were men who remained in their special field. That called to mind his own experience. The neurologist might give an opinion which would be of no value to the otologist, and he supposed it was the same way with the otologist when consulted by a neurologist,—he remained an otologist. This paper called attention to the requirement of having men specialize extensively, and yet know enough of the borderline subjects to get over the borderline into the other fields when necessary.

DR. GEORGE E. SHAMBAUGH stated that while he was very much interested in the tests of the vestibular mechanism in diagnosing intracranial disease, he did not care to go into a discussion of this at the time. He was much pleased to hear from Doctor Sachs emphasis laid upon the importance of the cooperation between men practicing in various lines of medicine. Patients very frequently consult a specialist in medicine because they have reached the conclusion that certain symptoms from which they are suffering are caused by disease of a local part. In these cases the patients are attempting to make their own diagnosis. In many of these cases the problem is not one for the specialist at all but for the internist. In most cases of suspected systemic infection the decision as to the nature of the trouble, and especially as to the question whether disease of the local part should be corrected, should be made by the internist instead of the specialist. In this way it would be possible to avoid unnecessary operations. The specialists were coming more and more to cooperate in their work with the internist, and this was being done in most instances without any partnership arrangements. He was inclined to believe that the interests of the patient were probably best taken care of in this way.

DR. CASSIUS C. ROGERS believed Dr. Sachs brought out one point which should not be overlooked, and that was the point of simple operations upon the skull,—not to do too much at the original operation. Surgeons did not hesitate to do two or three laparotomies on patients at times, and should not hesitate to do that many operations on the skull if necessary. It was no more difficult to open the skull than to open the abdomen, and no more difficult for the surgeon who knew his business to operate on the brain than for the abdominal surgeon to operate in the abdomen. He thought not enough attention was paid to local conditions in the cranial cavity. It did not take much irritation to the dura mater to produce severe pains, as its nerve supply was the fifth nerve. Many cases of localized leptomenigitis could be relieved of the pain by removing a plate of skull without doing a decompression operation; the dura need not be opened. He thought X-ray pictures were not worth anything unless they were stereoscopic views, and then they must be read correctly. He thought all branches of medicine should work together, taking the benefit of each other's knowledge, and not depending too much upon

the X-ray picture, or the symptoms, but upon the findings and symptoms and X-ray pictures together. No head should be opened without a thorough X-ray examination and if it was found that the patient had intracranial pressure one should do a decompression. In this way blindness could be prevented, even though they kept the tumor. He had seen patients with Sir Victor Horsley who had bigger tumors on the outside of the head than brain inside, but they had no pain, no gastrointestinal symptoms and were happy because they were relieved of their pain.

DR. ALFRED LEWY said that Dr. Sachs had answered one important question in regard to vestibular reactions; namely, that variation from the normal as shown by the Barany tests, unsupported by other evidence of organic lesion of the brain, did not of itself warrant the opinion that an organic lesion existed. We knew that the application of these tests often brought about pallor, sweating, tremor and other indications of vasomotor and nervous disturbances, and it was reasonable to suppose that these disturbances might react upon the vestibular nerve and its connections so as to derange its function. As a matter of fact, it had been found by men who had made many of these tests and had developed a good examination technic that patients who at one or more examinations would give an abnormal reaction, at another would react normally. He would like to have Dr. Sachs give his opinion on the converse of this question; namely, in the presence of normal vertigo, past pointing and nystagmus reactions, would he consider that an organic lesion of the posterior fossa had been definitely excluded?

DR. ERNEST SACHS, closing, thanked the gentlemen for their generous discussion and thought he had been treated very kindly.

DR. CARL BECK had mentioned one thing which seemed to him to go to the crux of the matter and that was why the surgeons had not cooperated as much as they should. He realized that the neurological surgeon was just as guilty as anybody else, but thought the lack of cooperation went away back to their training in medical schools and immediately after graduation. He thought the best thing every medical graduate could do was to take a medical internship before they ever started the practice of surgery. No one should go into a specialty until they had received a general training.

As to the case cited by Dr. Joseph Beck, he could quite understand his feelings about the way the case was handled, but he felt that up to the present time they had been rather handicapped in the neuro-surgical cases because of the fact that the other specialists had hesitated to have their patients operated because of the poor results which had been recorded up to the present time. The Continental surgeons gave a mortality of forty to fifty per cent, but Harvey Cushing reported a mortality in over one hundred cases of less than ten per cent. None of the Continental surgeons, with perhaps one exception, had specialized in these cases. For that reason he had always urged that anyone who was doing neurological surgery ought to be able to make his diagnosis himself. His teacher, Victor Horsley, would never take a diagnosis from any of his associates; if he operated he decided for himself where the lesion was.

Regarding the question of choked disc, he was much interested in what Dr. Burkholder said. They had only recently succeeded in getting the name "choked disc" adopted. Not so many years ago the ophthalmologists insisted on calling it optic neuritis. It had always seemed to him that the experimental work which had been done, the best of it in this country, had proved absolutely that those changes in the eyes variously called choked disc, or papilledema, or optic neuritis, were pressure phenomena. The most recent work, done by Parker of Detroit, absolutely proved this.

He heartily endorsed what was said about stereoscopic pictures of the skull and believed that it was very important to be able to interpret the plates correctly. He believed that relieving patients of their pain and headache and leaving tumors on the outside of the head larger than the brains inside was one of the things that had tended to do neurological surgery harm, because this total disregard of the appearance of patients was an unfortunate thing. He thought the cosmetic effect should always be considered. For that reason the decompressions which were well protected by muscle and fascia were

more desirable than those which led to cerebral hernias which might be very deforming. He hoped he would be pardoned for drawing attention to one statement with which he could not agree; no decompression could be said to be a true decompression unless the dura was opened, because it was the dura which interfered with the expansion of the brain more than the bone. He thought it was always necessary to open the dura widely.

He had hoped that Dr. Shambaugh would have more to say on the subject of the Barany tests. The question had been asked, "Can you have a lesion in the posterior fossa if the Barany tests were normal?" Yes, it was not at all uncommon to have a tumor even of considerable size without any disturbance in the Barany test. There could be a lesion of the cerebellar cortex which was quite large, and if the nuclei of the cerebellum were not affected there might be no symptoms at all. He always had the Barany tests made, but had yet to see a case of cerebral tumor in which the diagnosis could not be made without the Barany tests.

CHICAGO OPHTHALMOLOGICAL SOCIETY

A regular meeting was held April 15, 1918, with the president, Dr. Heman H. Brown, in the chair.

CONVERGENT STRABISMUS TREATED BY ATROPIN AND GLASSES, WITH SOME CASES OF HEREDITARY STRABISMUS.

Dr. Clarence Loeb read a paper on this subject in which he quoted freely from a paper on "Strabismus by Valk," read before the American Academy of Ophthalmology and Oto-Laryngology, in 1914, in which this author advocated the treatment of strabismus invariably by operative measures. Shortly after Valk's article appeared, the essayist investigated the results of the strabismus cases he had treated by his usual method of the daily use of one per cent. atropin for about a month, followed by complete or almost complete correction of the refractive error. Of 29 cases, one never wore the glasses prescribed, and one wore them only three months. Of the other 27 cases, 11 were straight, 6 almost straight, one good, 5 improved, and 4 unimproved, that is, 40 per cent. cures, 45 per cent. improvements, and 15 complete failures. The results were apparently as good when the refractive error was a compound hyperopia with anisometropia, as when it was a simple hyperopia.

Dr. Loeb also reported 33 cases of hereditary convergent strabismus, some of which were reported in the 29 cases previously referred to. The remainder did not report for subsequent examination, so that he had no means of determining the ultimate results. To summarize, there were 12 families showing direct heredity, with 35 children, of whom 15, or 43 per cent. were affected. Seven families showed indirect heredity, with 24 children, of whom 8 or 33⅓ per cent. were affected. Twelve families showed collateral heredity with 48 children, of whom 27, or 56 per cent. were affected. It would seem that both the number of children affected as well as in percentage, collateral heredity was more dangerous. Next in importance came direct heredity, while indirect heredity affected only one-third of the children in the families related to the patient.

THE SURGICAL TREATMENT OF STRABISMUS

Dr. H. W. Woodruff stated that the surgical treatment of strabismus must be considered when other methods of treatment have failed. In most instances the object to be obtained is cosmetic rather than an improvement in function, although that is occasionally obtained when the visual lines have been approximated by a successful operation.

The author has been doing the tucking operation for many years in preference to advancement, usually combined with partial or complete tenotomy of the opposing muscle. This operation has been done without the use of the tendon tucker. Briggs, he said, has apparently simplified the tucking operation by his method of clamping a wire loop over the folded tendon, capsule and conjunctiva. It occurred to the speaker that if this operation would exclude the conjunctiva and catgut sutures were used in place of wire, it would be ideal. He has not as yet completely satisfied himself that the older tucking operation which he has been using for many years should be given up. However, the simplicity of the new one recommends it.

After describing the tucking operation, the essayist drew the following conclusions: 1. Operate at any age when local anesthesia is permissible and nonsurgical measures a failure. 2. Never do an advancement, but always a tucking in any degree of actual concomitant strabismus. 3. Tenotomize the opposing muscle, when necessary, to increase the effect of the tucking. 4. In convergent strabismus, never secure an overeffect when tenotomy is used. If such a result is accidentally obtained, correct at once by a suture. 5. When complete tenotomy is performed, guard against the sinking of the caruncle by using a conjunctival suture. 6. In paralytic strabismus the operation of tendon transplantation should be used.

DISCUSSION.

Dr. Robert Von Der Heydt stated that there are more eyes lost to usefulness from neglected squint than by all other causes. All squinters have a hereditary taint in the form of a muscle imbalance. This together with reduced visual acuity in the one eye from any cause or high hypermetropia will bring on a squint. Alternating strabismus is so marked a muscle imbalance that it overcomes the fusion tendency, or the angle may be so that the object looked at falls on the blind spot of the squinting eye, hence monocular suppression is more easily acquired. Refraction under a cycloplegic is the first step in the treatment of squint. In case of failure to create parallelism by glasses, atropin in the fixing eye may be used. If we can by its use transfer the work to the squinting eye, we may educate this eye to fixation, later fusion and permanent parallelisms. If not, occlusion must be resorted to. A method of handling this variety of squint he presented at the meeting of the Society last October.

Dr. D. T. Vail, of Cincinnati, Ohio, stated that the teachings of Valk conformed so closely to his own ideas and observations that he feels there has been no real contribution to the etiology of strabismus since Valk's publication some ten years ago. He believes that Valk stated that so-called amblyopia exanopsia is one thing and congenital amblyopia is another. We may have congenital amblyopia with no strabismus. He has seen many cases where the affected eye was perfectly straight and had only 20/200 vision and could not be improved with any amount of atropin, training or glasses. The

same is true where the congenital amblyopia is associated with strabismus. Nothing improves the vision in true congenital amblyopia. Amblyopia exanopsia associated with convergence is entirely different. Here we have an amblyopia because the child has an exanopsic eye which is possessed of a high degree of ametropia, and the visual image in it is suppressed. Usually there is compound hypermetropia, and the convergence is caused by the excessive action of the internal rectus association with accommodation effort. In such cases one may almost invariably accomplish a good deal by glasses, atropin and training.

There are many different types of convergent strabismus, and each case must be studied on its own merits and a differential diagnosis made. He has seen quite a few cases with double paralysis of the sixth nerve in which there was inveterate double convergence. In these cases the refraction and vision in each eye may be normal, and yet the convergence is extreme, with no power in either eye to bring the axis of vision beyond the median line. Such patients will use the right eye for seeing objects in the left field, and the left eye for objects in the right field. In spite of everything one may do, these patients will continue to "cross fire."

Referring again to the subject of congenital amblyopia, the speaker called attention to the excellent book of Collins and Mayou on "Pathology and Bacteriology of the Eye," stating that this book contains an explanation of what congenital amblyopia is, why it is, and why it is that no amount of treatment or operation succeeds in improving it. Collins, he says, teaches that there is a lack of differentiation of the macula lutea in congenital amblyopia. By this he means that the macula lutea is not particularly different from any other part of the retina. There is no macula lutea. If one will examine the region of the macula in a case of congenital amblyopia ophthalmoscopically and compare its appearance with that of the seeing eye, he could satisfy himself that this teaching of Collins is correct.

When about to undertake an operation for concomitant squint on little folks four or five years of age, the author sometimes has been surprised to note that the condition has entirely disappeared under the anesthetic. He has seen cases in which the eye that was convergent became markedly divergent under the anesthetic. During sleep such eyes must be divergent and during waking hours convergent. He has tenotomized cautiously such cases with success, and in some of them has noted in after years a well developed divergence. On the other hand, he has seen such cases that after ten or more years have perfectly straight eyes with normal fusion power. Another class of close range can fuse very nicely and hold the focus, but the moment the accommodation relaxes, as when looking at infinity, the poorer eye becomes divergent. He thinks it is best to use the plan of atropin and glasses when there is a strabismus of less than 15 degrees. When it is more than 15 degrees, he recommends tenotomy. A simple complete tenotomy would insure 15 degrees of correction, but not more than that.

As regards tucking, he thinks it is only a temporary affair. The temporary help which it gives is very great, and it really amounts to a permanent cure in many cases. But the tuck unfolds in ten days or a few weeks and is no longer a tuck. In order to accomplish any good with a tuck one must cut or weaken the opposing muscle. The speaker has accomplished just as good results by putting in a reef-stitch as by the tucking procedure, but a reef-stitch will not hold as long as a tuck, it pulls out sooner. The reef-stitch is used for divergent strabismus where one cannot get too much effect and is not worrying about convergence following. He puts a strong stitch in the sclero-corneal tissue and carries the needle deeply through the substance of the caruncle, and then by tying the margin of the cornea flush with the caruncle, he can, in divergent strabismus, produce a marked temporary overcorrection which compels the severed tendon of the external rectus to retract, thus gaining the desired permanent result with no fear of permanent convergence. The stitch is removed in the third, fourth or fifth day.

Dr. Oscar Dodd thinks that the question of the treatment of strabismus can neither be considered purely operative nor as one in which atropin and glasses are used. Every case of

strabismus, unless it is in cases of adults who have had strabismus for years and where operation is indicated simply for cosmetic reasons, should be gone into very thoroughly and studied under atropin and correction with glasses to see how much effect can be gained. Most of the children with strabismus who come to him are amblyopic to quite a large degree in the converging eye. If one is practically normal and the other one has less than 20/40 vision, the use of atropin and the correction of the hypermetropia and astigmatism with glasses will not effect a cure. In most of those cases one has only begun treatment. When the patients are young, six, eight or under ten years, he finds that it is necessary to keep the good eye covered constantly, sometimes for several weeks, to correct amblyopia. When that is done, he has seen the vision improve, from 22/100 to 20/40 in a few weeks. Using the amblyopic eye alone for one or two hours daily is absolutely ineffective. Educational treatment and development of the fusion sense with the amblyoscope is of value, but it is difficult to use with children. If the amount of strabismus is 10, 15 or 20 degrees after securing all the benefit possible from the use of glasses, he believes operations should be done. He is not successful in operating on children under local anesthesia, as it is very rarely that they will submit to the operation which he deems necessary. He would not do a tenotomy on a child, expecting it to be permanent, because he has had patients return after 10, 15 or 20 years with divergence, when the results of the operation seemed absolutely perfect at first. Nothing should be done in these cases but tucking and advancement. In the tucking operation he puts his stitches through the insertion of the tendon so as to get a good fixation point, using catgut which absorbs in from 10 to 20 days. Doing a tucking operation with the instrument Dr. Woodruff has demonstrated is certainly a very easy and quick method.

Dr. Joseph Elliott Colburn stated that he devised a muscle tucking operation at about the time when the American Medical Association met in Cincinnati and made a preliminary report on it. An instrument maker made for him a muscle tucker at that time. He did not follow up the use of the tucking operation because he found that he had a rather annoying puckering, so that after two or three years of use he abandoned it almost entirely, excepting as an aid to general tenotomy tucking on the opposite side.

The various means of operating, whether to tuck or advance, are debatable. One should take into consideration not only the condition of the refraction, but the anatomical condition of the eyes and head.

Dr. William A. Mann stated that when a patient first comes in for examination, if the convergent eye will not fix and stay fixed, he has very little hope of doing anything with atropin, if the vision shown is 22/100 or less. In these cases, if one will cover the good eye, the other eye will wander. On examination one finds not only an absence of the macula lutea but an increased number of blood vessels in the macular region. One may find the blood vessels almost running through where the macula should be. In those cases of congenital amblyopia glasses are practically no good. He does not recall a single case where he has succeeded in developing central vision.

Dr. Robert Von Der Heydt, in connection with the discussion of tucking methods, exhibited a little silver clamp he has designed for advancing a muscle. The muscle to be shortened is drawn through the clamp and held by two screws. It is then left in the eye until the strangulated muscle sloughs off. He has used it in three cases thus far with success. It took eleven, twelve and fourteen days respectively. Some of the clamps were passed around for inspection.

Dr. Clarence Loeb, in closing on his part, stated that he did not agree with Dr. Von Der Heydt in regard to the success in alternating strabismus. Those cases, as a rule, have been most successful under the treatment described.

As to Dr. Vail's statement about paralytic squint, one could not expect any improvement from the use of glasses, but he could not expect it, on the other hand, from the operative side. The report was rather an attack upon the theory that all cases should be operated rather than to insist that all cases would be cured by the use of glasses and treatment.

As to the question of differentiating between amblyopia exanopsia and congenital amblyopia, the speaker does not think it is quite as simple as indicated. He has examined quite a number of young children with convergent strabismus, and although one eye had less vision than the other, he could not recall that there was any difference in the macula. The question of strabismus and amblyopia exanopsia is not that the strabismus results from the amblyopia, but that the strabismus causes it. If this were not so, he could not explain the experiences of the last couple of months in connection with advisory boards, where they have had quite a number of patients whose vision in one eye was decidedly below the other, and at the same time there was no strabismus. If amblyopia causes strabismus there should be a much higher degree of strabismus than found.

Dr. Woodruff, in closing, stated that in paralytic strabismus the operation of tendon transplantation should be used.

The speaker has seen and has operated on two cases of paralysis of the external rectus muscle. The etiology in one case was possibly traumatic, a head injury; at least, that was the only history obtainable, while the other was probably a congenital case. It was his first experience with muscle transplantation, and the result was much more satisfactory than with any other operation which he had ever attempted. In a paralysis of the external rectus parallelism can be maintained looking straight ahead, but with very little ability to rotate the eye outward. That was his experience in these cases, but one of these cases gave an exceedingly gratifying result. This case was described in detail.

CASE FOR DIAGNOSIS

Dr. Lawrence J. Hughes, of Elgin, reported the following case: Mrs. J. R., aged 22. Referred by Dr. R. on March 25, 1918, who asked for a fundus examination. Patient's mother died seven years ago, at the age of 39, from uremic poisoning subsequent to the removal of the kidney for tumor. Mother was subject to severe vomiting spells and headaches, which lasted several days at a time.

Personal history: Patient has had most of the diseases of infancy. Typhoid fever at 10 years. Was poisoned from milk when several weeks old and has been sickly since. In 1913 she was ill for several months with what a physician called the early stage of tuberculosis in the left lung. She spent several months in the country and apparently recovered. She had scarlet fever in 1915.

Present history: Has been subject to headaches for several years. Last July she had a very severe headache accompanied by nausea and vomiting, dizziness, and a tendency to fall to the right side. There was very severe noise in the head and right ear at that time. At first, the headache came at intervals of one month, at the time of menstruation, but later became semi-monthly, and at present weekly or more often. Patient states that after the attack she feels like a man "after a jag." There is a tendency to fall to the right for several days, and lying on the right side causes a feeling of dizziness and falling to the right. Headaches are frontal and fronto-occipital. Of late the menstrual flow is getting less. She is deaf in the right ear, is losing weight continually. She has been married for six months, but no pregnancy. No loss of vision in an attack, but there is marked increase in the head noise.

Patient looks worn and rather anemic. Nose shows

a septal deflection to the left side with congestion of the inferior turbinate. Sinuses negative. Throat negative. Right drum retracted but motile; reflex still present; no congestion. Left ear negative. Hearing: Galton all the way, both ears. Voice, right ear loud voice at 14 feet, whisper at 8 feet. Left ear normal. Turning to the right produces dizziness with a tendency to fall to the right. No nystagmus. To left normal. Tubes normal in both ears. Inflation does not improve hearing. The appearance of the eyes is normal. Tension normal. Reaction normal to light and accommodation. Vision of 20/20 in each eye. Fundi: Right eye normal; left eye choked disc of about two dioptres. Fields: Right eye normal; left eye contraction of form field to 35 above, 30 nasal, 60 temporal, 30 below. Concentric contraction of color fields. No active specific infection, but reaction sufficient to say an inherited type of infection. Blood pressure: Systolic, 130, and diastolic, 100.

Dr. Hughes stated that his object in reporting this case was to get some information as to the nature of the lesion and where it is located.

DISCUSSION.

Dr. Robert H. Good stated that the case appeared to be one of intracranial pressure. There was some edema of the right optic disc as well as the left. In addition there is involvement of the right ear. The patient became sick suddenly in July with severe headache, nausea and vomiting. This nausea still continues every time she has a recurrence of the headache. According to the patient, there is a peculiar numbness in the right arm and right leg. The speaker recommends lumbar puncture with a view to determining the pressure of the spinal fluid. If the pressure is shown to be increased, one knows then that there is an increased intracranial pressure. The picture resembles to some extent that of cystic involvement of the temporal lobe of the right side of the brain. On pressing the head very hard the right temporal region is very tender. The patient complains very much from this pressure, so that the lesion is undoubtedly located in the right temporal lobe of the brain. Wherever one finds marked tenderness in a certain area, it is usually a fairly good indication of the location of the trouble. He is absolutely of the opinion that if a lumbar puncture shows an increased intracranial pressure, this patient should have a decompression. That it is not a tumor one may assume from the fact that the attacks occur at intervals and between intervals. There is no headache and no pain. If there were a tumor present, one would expect the sight to be impaired by this time. It is probably a cystic condition of the right temporal lobe of the brain.

Dr. D. T. Vail, of Cincinnati, said the case of Dr. Hughes is one of interest on account of its obscurity. The history of headache and vomiting associated with other symptoms seems to clearly indicate excessive intracranial pressure. The case calls for a careful differential diagnosis, but the onset is so recent and the symptoms so indefinite, that about all one can now say for certain is that there is increased cerebral pressure, and that is a condition common to several distinct and widely differing brain maladies. The speaker is impressed with the thought that the present stage is transitory, and that later on characteristic symptoms will establish themselves so that a definite diagnosis will then be possible. In differentiating one should first endeavor to learn whether the lesion is anterior or posterior, whether at the cortex or base, also whether above or below the tentorium. The study of the pupils affords the most valuable evidence. Unfortunately the pupils are now dilated with a mydriatic for aiding ophthalmoscopic examinations, but Dr. Hughes reports they were entirely normal. Normal pupils in a brain case excludes internal hydrocephalus or distention of the third ventricle.

This is very important and enables one to say at once that the region of the third ventricle is not directly involved. Hydrops of this ventricle would affect the pupils and also the third nerve, for the pupillo-motor fibers as well as the fibers of the third nerve have their centers along the floor and sides of this ventricle.

The next question is, could these symptoms arise from hypophyseal disease. One sees so many variations from the classical symptoms of hypophyseal disease that the typical acromegaly is the rare exception. The study of this case is not complete until a transverse radiogram is taken to demonstrate the size and depth of the sella tursica, and if the clinoid processes are eroded or displaced.

Then comes the question of tumor of the right auditory nerve. Neuroma affecting the eighth nerve would produce all of the symptoms one finds in this patient. The auditory nerve trunk is short and composed of two kinds of nerve fibers. Where these nerve fibers merge is the favorite site for the development of a neuroma. The location is usually just where the auditory nerve enters the internal auditory meatus. He ventures to predict that after Cushing reports his series of cases, their operations and cure, one will be looking for them and he will find them. The symptoms are Menier's complex, profound tinnitus, total deafness and ocular symptoms such as checked disc, nystagmus, etc. Cushing has diagnosed and operated on eight cases during the year preceding the entry of America into the present war with Germany. The operation is simple. An incision is made, the scalp stripped from the temporal bone, the bone flap raised, and just inside the skull lies the fusiform tumor of the auditory nerve. The dura is not opened. An incision is made in the dural sheath of the nerve and the tumor mass is curetted away. The growth is semi-benign. The amazing thing is that the hearing is restored in about 50 per cent of Cushing's cases. The ordinary functional hearing tests are of no value. Baranay's tests must be made. The present case should be examined in this way to determine whether this disease is present. It enters into the differential diagnosis and must be excluded. The optic neuritis and increased cerebral pressure are present because the tumor lies below the tentorium. Weeks' statistics published in his textbook show that 100 per cent of tumors of the cerebellum have papilledema. In almost 15 per cent of the cases the choked disc is on the side opposite to the tumor.

Next comes the question of tumor of the cerebello-pontine angle. An oncoming tumor in this location would present all the symptoms this case exhibits. Later on the hemiplegia and also the strabismus due to paralysis of the sixth nerve, as well as the palsy of the intraocular muscles from internal hydrocephalus affecting the third nerve centers, will show themselves, and then the diagnosis of cerebello-pontine angle tumor will be easy. Deafness, optic neuritis, sixth nerve palsy, third nerve palsy, hemiplegia, vomiting, headaches, etc., are characteristic symptoms of tumor in this location. The optic neuritis on the opposite side is not inharmonious with tumor of the angle in the presence of sub-tentorial increased pressure.

Dr. Vail said that other conditions causing monocular optic neuritis, such as tumor or abscess of the sphenoid or posterior ethmoid cavities are to be thought of and examined for, although he hardly expects confirmatory evidence will be found favoring this group of diseases, for the other symptoms, deafness, dizziness, vertigo, vomiting and headache are not common to disease of the sphenoid and ethmoid cavities.

Dr. Alfred N. Murray said that he reported a case about eight or nine years ago which had symptoms somewhat similar to those in Dr. Hughes' case. The left ear was totally deaf. There was choking of the right disc. Dr. Halstead operated and found a cyst at the left cerebello-pontine angle about the size of a hen's egg. Vision almost immediately began to clear up. Vision in the left eye returned to normal, and in the right eye, where the choking was, did not return completely to normal, but remained about 20/30. There were no typical symptoms of labyrinth disease. Total deafness in the left ear was evidently due to pressure on the auditory nerve. He saw the patient about two months ago, and his vision is just as it was when he left the hospital eight years ago. He

is working at his trade the same as ever, and apparently suffers no inconvenience of any kind.

Dr. Smith said that in making a diagnosis of auditory tumor one should consider all the symptoms. There are some symptoms that are indicative of a central lesion and the patient has a tendency to fall in one direction. In locating lesions here in the temporal lobe one should bear in mind that the labyrinth apparatus and nerve fibers take a different course from those of seeing. He thinks the symptoms point directly to a right-sided lesion. The beginning choked disc is absolutely indicative of some pressure. A tumor of the cerebello-pontine angle, either on the eighth nerve or in close approximation would give all these symptoms, including disturbances on the right side. There is no very marked ataxia. There is a little difficulty in coordination, but not much. In operating he would not simply do a compression; he would go farther, as one might find something that could be removed. He fails to see any difference between a cyst and a tumor. He has never been able to see any difference in making a diagnosis, from the symptoms. A spinal puncture is indicated and should be done gradually, care being taken not to let all the fluid escape at once. A cell count and Wassermann of the spinal fluid should be made. A positive colloidal test would indicate syphilis. One might combine with decompression massive doses of potassium iodide, mercury or arsenic. Operation should not be delayed too long. Subtemporal decompression is the operation of choice, if one is sure there is nothing more there, but the speaker would advise a cerebral decompression.

RED CROSS PRACTICE

(Continued from page 85)

that can be saved from partial and total blindness is large and the economic value of each eye thus saved is enough to make the prosecution of this line of work of the greatest importance for the redemption of the land.

"The accident cases are always interesting. I had the last end of treatment of some cases of bombed hands, of which there had been quite a number in the earlier days. These were largely in children, and were due to their picking up unexploded Turkish bombs that were lying in the fields from the time of the British advance in the Gaza region. Many fingers and even hands were lost from this cause.

"Vermin was the great enemy we had to fight. Fleas were hardly counted as a problem because we could do nothing against them, they were everywhere and inevitable, and so far as we know at present not being the carriers of any special disease, did not come within the hostility of a medical conscience.

"Lice and maggots were a daily terror. How many wounds and injuries came to us filled with maggots I cannot tell. A favorite dressing for a wound is a piece of raw meat, a breeding place for maggots, and they can hardly be blamed for invading the adjoining premises.

JO DAVIESS COUNTY

The Jo Daviess County Medical Society held its annual meeting at Warren, Ill., Jan. 30, 1919.

The following program was given: "My Experience with the 'Flu,'" Dr. J. C. Renwick, Warren; "My Connection with the Medical Corps," Lieut. H. F. Smith, Galena; "My Observations at Fort Riley," Capt. F. H. Fleege, Galena.

The most important thing to come before the society was the proposed amendment to the Medical Practice Act requiring the annual registration of physicians.

This brought out some vehement remarks by the physicians present, a sample of which I give. Dr. Kreider: "I consider it the most damnable piece of dirty work that was ever attempted by a bunch of cheap skate politicians."

Dr. Rice: "The approval of this amendment by a committee of the House of Delegates goes to show that the several county societies should send to the House a higher class of men. I consider it an outrage and an insult to the profession of the state. It places the physician on the same plane as the barber, the plumber, and the saloon keeper."

The following resolutions were unanimously adopted:

A motion was made by Dr. Rice that a committee on quacks and fakers be a permanent one of the society, whose duty shall be to report to the State Board of Registration and Education all quacks, fakers and itinerants operating in the county.

Dr. G. W. Rice, Secretary.

The motion carried.

Jan. 30, 1919.

WHEREAS, An effort is being made to amend the Medical Practice Act of Illinois to provide for the annual registration of physicians, and demanding that the physician's right to practice his profession be reviewed annually by the Department of Registration and Education together with a committee of "reputable physicians licensed to practice medicine and surgery in the state," and

WHEREAS, Said Department claims that the intent of this bill is to protect the people of this state against the quacks and fakers preying upon the ills and ignorance of the people, and

WHEREAS, We believe this purpose can be accomplished more effectively through the action of the medical profession itself without the imposition of an annual registration of the physicians of this state, therefore, be it

Resolved, by the Jo Daviess County Medical Society, That we believe this proposed amendment is vicious, a direct slam at the medical profession of this state, lowering the dignity of the profession, placing us on the same plane as the barber, the plumber and the saloonkeeper, promoted, as we believe, by those in sympathy with the pseudo medical cults; be it further

Resolved, That we believe that the State Department of Registration and Education should use more diligence, with the means at hand, in the investigation of quacks and fakers, and instruct the several state's attorneys to be more diligent in the prosecution of this itinerant gentry; be it further

Resolved, That a copy of these resolutions be sent to each of the representatives and the senator of this district, to the Chairman of the Department of Education and Registration, to the Editor of the ILLINOIS

MEDICAL JOURNAL, and to the Chairman of the Committee on Legislation of the State Medical Society.

These resolutions were unanimously adopted by the Jo Daviess County Medical Society at its annual meeting at Warren, Illinois, January 30, 1919.

DR. F. H. FLEECE, Pres.

DR. G. W. RICE, Sec.

PIKE COUNTY

The Pike County Medical Society met in Pittsfield, Thursday, January 30, and a goodly number was present.

The minutes of the last meeting were read and approved. The society put itself on record as opposed entirely to the proposed excise bill pending in Congress, which would about double the cost of drugs to the "ultimate consumer." As a matter of fact, it is believed that the aforesaid gentleman has about all he can stand, anyway. It is believed we have a surfeit of laws already, and that it is better for all concerned to abide by the laws we already have and see that they are enforced, rather than to see how many new ones can be placed on the statute book.

The society rejected by a large vote the proposition to have every doctor in the State of Illinois register every year; it was thought that one registration was enough.

Dr. Claude Fortune, formerly of Sangamon county, was present, and after presenting his card from Dr. B. B. Griffith, secretary of the society of that county, was received as a member in full standing.

Drs. Allworth of Griggsville and Chiasson of Nebo were present and will become members at the next regular meeting.

Dr. F. N. Wells, formerly captain in the Medical Corps of the army at Fort Sheridan, then read a very interesting and instructive paper on "My Experiences in the Service." This was quite a comprehensive narrative of the day's work at Fort Sheridan, comprising many details of the life, experience, news, varieties of cases seen and schedule of procedure.

This meeting was a very successful one, and as quite a number of its members are still in our country's service, we expect a stronger, better and more vigorous society than ever when they return.

W. E. SHASTID, Secretary.

ST. CLAIR COUNTY MEDICAL SOCIETY ANNUAL MEETING.

The annual meeting of the St. Clair County Medical Society was held in the rooms of the Chamber of Commerce, East St. Louis, January 9, with 21 members and guest of the society, Dr. H. F. Killene, present.

Drs. Pierce J. Fullerton, G. O. Hulick and H. F. Killene were admitted to membership.

Officers were elected as follows: President, Walter Wilhelmj; vice-president, John C. Gunn; secretary, C. W. Lillie; treasurer, A. E. Hansing; censors, H. Ressel, E. W. Cannady and J. G. Beykirch; dele-

gates to State Society, C. S. Skaggs and Walter Wilhelmj; alternate delegates, A. E. Rives and Philip Griesbaum; medico-legal advisor, C. A. W. Zimmermann.

President Walter Wilhelmj delivered the presidential address, in which he touched upon some very vital questions, and which elicited considerable discussion.

Motion by Dr. Skaggs that a public utility committee be appointed to confer with other organizations on all matters pertaining to the public health, or of general or special interest to the people of the county. After discussion the motion prevailed, and the president appointed Dr. R. L. Campbell, Dr. A. C. Housh and Dr. C. S. Skaggs on the committee.

Reference to the death of Dr. George C. Adams was made and Dr. R. L. Campbell and Dr. C. A. W. Zimmermann were appointed a committee to draft and present a suitable memorial or resolution in his honor.

Dr. A. E. Rives presented an interesting paper on "Nitrous Oxide and Oxygen Analgesia in Obstetrics." Subject discussed by several members.

Society adjourned.

C. W. LILLIE, Secretary.

Personals

Dr. Walter S. Haines, Chicago, has been appointed a state food standard officer.

Dr. and Mrs. I. F. Harter of Galesburg are spending the winter in Los Angeles.

Dr. Howard L. Metcalf of Springfield received painful injuries in an automobile collision.

Dr. and Mrs. George Paull Marquis of Chicago are spending the month in Florida.

Dr. W. S. Howell of Winnebago is suffering a severe infection from the bite of a cat.

Dr. and Mrs. J. C. Corbus of Mendota are spending the winter in Miami, Florida.

Dr. A. B. Snider has removed from Tinley Park to Blue Island.

Dr. Dent H. Howell has returned from the army and has opened up his office at 901 Irving Park boulevard, Chicago.

Franklin H. Martin, colonel, M. C., U. S. Army, who went abroad, November 9, reached New York, January 16, ill with bronchitis.

Dr. Walter Wilhelmj has been elected chairman of the social hygiene clinic of East St. Louis.

The La Salle County Tuberculosis Sanitarium at South Ottawa was formally opened to the public, February 2.

Dr. Fred M. F. Meixner has been appointed commissioner of health of Peoria, to succeed Dr. George Parker, who has resigned.

Lieut.-Col. Milton Mandel, M. C., U. S. Army, who went abroad as chief of the medical staff of Base Hospital No. 12, has returned to Chicago.

Lieut.-Col. Frederick A. Besley, M. C., U. S. Army, has returned to Chicago, and will go for a short vacation to California.

A. F. Stotts, lieut.-col., M. C., U. S. Army, has received an honorable discharge from the service and returned to Galesburg.

Lieutenant Dana M. Littlejohn of Peoria has received an honorable discharge from the U. S. Medical Corps.

Leonard S. Wood, major-general, M. C., U. S. Army, has assumed command of the central department, succeeding Thomas H. Barry, major-general, U. S. Army.

Dr. Edmond D. Converse, Chicago, was arrested, December 30, after having, it is alleged, pleaded guilty to the sale of 600 grains of heroin to a young man and woman at his office.

Lieutenant J. A. Connell of Waukegan has been appointed chief eye surgeon and consultant to the U. S. General Hospital No. 39 in New York.

Dr. Edmund W. Weis, Ottawa, who was recently appointed head of the hygienic institute, La Salle, has donated his entire medical library to the Ryburn Memorial Hospital, Ottawa.

Julius H. Hess, major, M. C., U. S. Army, received his discharge, December 25, as chief of the medical service of General Hospital No. 25, Fort Benjamin Harrison, Ind.

Dr. Frank Smithies has been appointed medical consultant to the United States Marine Hospital at the port of Chicago, by the Surgeon-General of the U. S. P. H. S.

Dr. John Fisher, Chicago, received some unpleasant notoriety on account of refusing to attend an emergency call to attend a patient injured by a street car.

Dr. N. L. Seelye of Harvard has received an honorable discharge from the Medical Officers' Training Camp at Camp Greenleaf, and has resumed practice.

Capt. H. I. Davis, A. R. C., who has been chief of the neurologic service in the American Red Cross Evacuation Hospital No. 3, located at Treves, has been assigned to the Red Cross Commission for Relief to Poland and has gone to that country.

Dr. Louis J. Pritzker, until recently Captain M. C., U. S. A., and Chief of the Surgical Service, U. S. Army General Hospital No. 29, Fort Snelling, Minn., has returned to private practice which will be devoted principally to general surgery. He has located at 1332 Marshall Field Annex building, 25 East Washington street.

Captain Albert E. Mowry has received his honorable discharge from the ranks and staff of General Hospital No. 13 of the United States Army, January 29. The captain wears a service stripe of the Spanish-American war, and gave up a lucrative practice in Chicago to enlist his services in the past war for democracy. Captain Mowry was beloved by every one at Syracuse and Danville, N. Y., where General Hospital No. 13 is located.

News Notes

—Dr. C. M. Ranseen has been elected president of St. Anthony Hospital, Rockford, to succeed Dr. E. E. Ochsner.

—It is said that the Chicago Visiting Nurse Association is backing the plan to secure a law to license nurses taking a short practical course provided that a distinctive name is given to those who qualify.

—The Chicago Ophthalmological Society, at the annual meeting, elected Dr. W. L. Noble president; A. L. Adams of Jacksonville, vice-president; A. N. Murray, secretary-treasurer, and Douglas A. Payne, councillor.

—At the annual meeting of the Chicago Polish Medical Society, held Dec. 30, 1918, the following officers were elected: President, Dr. Wladyslaw A. Kuflewski; vice president, Dr. Marie T. O. Kaczorowski; treasurer, Dr. Francis F. Wisniewski, and secretary, Dr. Michael C. Goy.

—Dr. Ola A. Kibler, for several years head physician at the State Home for Boys, St. Charles, has resigned to accept a similar position in Milwaukee, and Dr. W. E. Weisman of the State School for the Feeble-minded, Lincoln, has been appointed to fill the vacancy.

—January 2, it was announced that Camp Grant has been selected among the eighteen cantonments designated as locations for reconstruction hospitals for the education and curative treatment of convalescent soldiers. Capt. Rouel H. Sylvester, U. S. Army, has been named as educational director for the new project.

—Charles H. Thorne, director of public welfare, has recommended that five new state institutions be established: an institution for feeble-minded near Chicago; a state sanatorium for women; a state farm for male misdemeanants; a surgical institution for children, and educational hospitals to perfect the training service. The appropriations required for the establishment of these institutions aggregate more than \$1,500,000.

—At the annual meeting of the Madison County Medical Society and the Madison County Anti-Tuberculosis Association, held in Edwardsville, January 4, Dr. Charles R. Kiser, Madison, was elected president; Dr. Frank O. Johnson, Granite City, vice-president; Dr. Edward W. Fiegenbaum, Edwardsville, secretary; Dr. Joseph A. Hirsch, treasurer, and Dr. M. William Harrison, Collinsville, medical director of the tuberculosis association.

—The director of the State Department of Registration and Education has addressed a letter to the secretary of each county medical society in the state asking information regarding the activities of traveling physicians who operate in the state of Illinois. The information desired is: (1) the names; (2) samples of advertising material used; (3) itineraries announced; (4) home addresses of itinerant physicians, and (5) information regarding citizens who may have fared ill at the hands of such practitioners.

Marriages

EDWARD JAMES LEWIS, to Miss Katherine Sproehnle, both of Chicago, December 18.

PONTIUS L. ERICKSON to Miss Malmfrid Nofzik, both of Chicago, January 11.

GEORGE ASBURY CONREY, Lieut., M. C., U. S. Army, to Miss Cornelie M. Keating, both of Chicago, January 18.

ADDISON EUGENE ELLIOTT, El Centro, Cal., to Dr. Frances Pullen Chapman of Oak Park, Ill., January 11.

EVERETT MORRIS, Capt., M. C., U. S. Army, to Miss Helen Bernedine Freer, both of Chicago, at New Haven, Conn., December 21.

Deaths

CHARLES H. BRUNK, Windsor, Ill.; Rush Medical College, 1865; aged 93; died at his home, January 4, from senile debility.

ANTOINETTE K. FELLOWS, Chicago; Hering Medical College, Chicago, 1896; aged 73; died at her home, January 5.

BALTNAZAR J. MEYER, Chicago; University of Christiania, Norway, 1877; aged 68; died at his home, December 30, from tuberculosis.

GEORGE GRANVILLE MONROE, Chicago; University of Michigan, Ann Arbor, 1878; aged 66; died at his home, January 8, from uremia.

WILLIAM C. FOWLER, Mount Sterling, Ill.; Missouri Medical College, St. Louis, 1887; aged 57; at one time a member of the Illinois State Medical Society; died at his home, December 18.

ARTHUR ROBERT OHMAN, Chicago; University of Illinois, Chicago, 1913; aged 27; a member of the Illinois State Medical Society; died at his home, January 11, from pneumonia following influenza.

WILLIAM P. C. SCHUNZEL, Chicago; Hahnemann Medical College, Chicago, 1917; aged 33; died at his home, January 20, from a ruptured aneurysm of the aorta.

ELIZABETH H. TROUT, Chicago; Northwestern University Woman's Medical School, Chicago, 1884; aged 70; died at her home in Austin, Chicago, November 23, from pernicious anemia.

JAMES F. WHITE, Richview, Ill.; Medical College of Ohio, Cincinnati, 1874; aged 73; a member of the Illinois State Medical Society; died at his home, October 20, from influenza.

ROBERT H. BRADLEY, Marshall, Ill.; Northwestern University Medical School, Chicago, 1873; aged 74; a Fellow, A. M. A.; died in his office at Marshall, January 4, from heart disease.

EDWARD B. GREENE, Chicago; Northwestern University Medical School, Chicago, 1885; aged 64; at one

time a member of the Illinois State Medical Society; died in the North Chicago Hospital, Chicago, December 17, from diabetes.

MILLVILLE CHARLES KORB, Chicago; Bennett Medical College, Eclectic, Chicago, 1896; University of Illinois, Chicago, 1907; aged 50; a member of the Illinois State Medical Society; died in the Washington Boulevard Hospital, Chicago, December 21, from nephritis.

PETER SYLVESTER MACDONALD, Chicago; Rush Medical College, 1864; aged 82; a Fellow, A. M. A.; for several years professor of anatomy in the Northwestern University Woman's Medical School, Chicago; died at his home, January 20.

JAMES FERGUSON CARMICHAEL, Chicago, Ill.; Bennett Medical College, 1914; a Fellow of the American Medical Association; died December 6 at the home of his brother-in-law, Colonel D. Spence, Brantford, Canada, from multiple neuritis, cause pyorrhea.

WILLIAM CHESTER SMITH, Captain, M. C., U. S. Army, Chicago; University of Louisville, Ky., 1904; University of Illinois, Chicago, 1913; aged 38; a Fellow, A. M. A.; on duty at Camp Sherman, Chillicothe, Ohio; died at that post, December 11, from valvular disease of the heart.

CARL C. ELMER BOYER, Chicago; Loyola University, Chicago, 1916; aged 32; a member of the staff of the Columbus Hospital; physical director for the north and south parks in Chicago for six years, and in Oil City, Pa., for two years; died at the Columbus Hospital, December 5, from pneumonia following influenza.

WILLIAM A. ALLEN, Donnellson, Ill.; Missouri Medical College, St. Louis, 1878; aged 62; a member of the Illinois State Medical Society; one of the organizers and president of the State Bank of Donnellson; died in St. Francis Hospital, Litchfield, Ill., January 5, from septicemia due to scratch of the right index finger.

SAMUEL LEO OREN, Lieut., M. C., U. S. Army, Lewistown, Ill.; Barnes Medical College, St. Louis, 1899; aged 39; a Fellow, A. M. A.; a specialist on diseases of the eye, ear, nose and throat; who after a course of training at Fort Oglethorpe, Ga., was sent overseas; died in France, October 9, from nervous collapse presumably following ambulant typhoid fever.

LOUIS BECKER, Knoxville, Ill.; Northwestern University Medical School, Chicago, 1888; aged 54; a member of the Illinois State Medical Society; physician in charge of the Knox County Almshouse and Insane wards, and physician to St. Mary School and St. Albans Academy, Knoxville; died at his home, about January 5.

ALPHEUS ALONZO BONDURANT, Cairo, Ill.; Bellevue Hospital Medical College, 1875; aged 68; a Fellow, A. M. A.; for many years recording and corresponding secretary of the Southeast Missouri Medical Association; died at his home, December 7, from the effects of a gunshot wound, self-inflicted, it is believed, with suicidal intent, while despondent on account of ill-health.

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Original Articles

HOW TO STUDY A HEART CASE AND HOW TO TREAT IT.

C. T. HOOD, M. D.

CHICAGO.

To Richard C. Cabot, M. D.:

A leader among men; a peerless teacher; an untiring worker and a pioneer in the classification of heart diseases.—THE AUTHOR.

The writer wishes to express his gratitude to Dr. Paul D. White of Boston, who rendered him much valuable assistance in polygraph study.

INTRODUCTION.

The classification of organic diseases of the heart, followed in these papers, is that given by Richard C. Cabot to his class in "Physical Diagnosis," and now adopted by many of his colleagues in the Massachusetts General Hospital, as well as by many physicians throughout the country.

This classification is the most logical yet presented to the profession, and gives a working basis for study.

It is not to be expected in a monograph of this size either that details can be given or arguments presented, but the author can testify to the facts as here stated.

Inasmuch as the records of the Vital Statistics of the United States show that organic heart diseases are responsible for more deaths than any other causes, not excepting tuberculosis and pneumonia, it behooves the general practitioner to grasp as much as possible of the etiology, pathology, clinical history, diagnosis, prognosis and treatment of these conditions.

When we glance through one of the many books on the heart, we are at once impressed with the vastness of the subject, and can hardly help feeling that it is too great and possibly too complicated for the general medical man, with his limited time, to undertake. If he reads the new

books, it is only to obtain the latest points in diagnosis and treatment.

We hope that as a result of many years of study and personal experience we may be able to cull, from our knowledge of the subject, the things necessary for the general practitioner to know, in order that he may be able to give to his cases of organic heart disease the best care, and be able to judge when he requires the aid of the specialist.

No attempt will be made to go into details, and no statements will be made that have not been accepted as facts by the leading men on the subject of heart diseases. Personal observations only will be given in treatment, but nothing except what years of experience have proven to be of value.

To many of the general medical men, the care of organic heart diseases involves a fair knowledge of heart murmurs, and the use of a few heart remedies. To many the subject seems difficult to understand, and the management of these cases unsatisfactory.

There have been such rapid strides in the understanding of organic heart diseases within recent years, so much of vital importance has been worked out, that, if the general practitioner can but catch the main points, many apparently complicated conditions will become fairly simple ones to understand.

The most important task in the proper, comprehensive understanding of the subject is to have a definite working basis.

When one listens with one's stethoscope to a heart, one may be able to correctly determine the valve or valves diseased, but this information is the least important of all the things to be investigated.

Let us see if we can outline a practical working basis for the study of organic diseases of the heart, out of the large accumulation of knowledge on the subject.

First: A normal contraction of the heart is the result of an impulse generated in the sino-auricu-

lar node or pace-maker, which is located in the right auricular appendix.

Second: This normal impulse, which when discharged and distributed to a normal heart muscle causes it to contract, can only be generated while the heart is at rest.

Third: The bundle of His conveys the normal impulse from the pace-maker to the heart muscle.

Fourth: The larger part of the bundle of His, which is situated on the right auriculo-ventricular septum, can produce an impulse when the heart is at rest.

Here and there through the heart's structure are bits of the primitive heart tube. These bits can also produce impulses when the heart is at rest.

These impulses produced by the bundle of His and bits of the primitive heart tube, when liberated and conveyed to the heart muscle, will cause the heart to contract.

Fifth: Certain fibers in the heart, notably those making up the bundle of His, possess the property of conduction, as well as that of contraction.

Sixth: The heart muscle, in health, possesses excitability, contractibility, and tonicity.

Upon the above factors depend the action of the normal heart. Heart efficiency is wholly dependent upon a normal heart muscle supplied by a normal circulation. In other words, a normal heart possesses the property of originating, when at rest, nerve impulses which are conducted to the muscular structure of the heart, and through its excitability, contractility and tonicity, a normal cardiac cycle results, with the maintenance of a normal systemic and pulmonic circulation.

It must be remembered that when the muscular structure of the heart has contracted, it can not contract again until it has rested, and that the longer the period of rest up to the normal rhythm, the more efficient the contraction will be. But if the circulation of the heart itself is impaired, the contractility, excitability and tonicity of the muscular structure are interfered with. This may be the result of inflammatory changes, inflammation in the heart muscle, or from hypertrophy or dilatation, with consequent imperfect heart action.

Therefore, a normal heart action depends upon a normal impulse generated within the pace-maker, a normal conduction of that impulse, a normal excitability of the muscular structure, and a normal contraction of the heart muscle.

With these facts in mind, it becomes evident that the most important factor connected with a normal circulation is a healthy heart muscle, and that any condition which either directly or indirectly interferes with the health of the heart muscle, means impaired heart function.

The heart possesses, first, an ordinary working power; that power which maintains a normal circulation when the body is at rest; second, it possesses a reserve power, which maintains a normal circulation upon exertion.

If the reserve power of the heart begins to fail, this failure is manifested first by fatigue and shortness of breath upon exertion. If it fails still further, the dyspnea and fatigue occur on slight exertion. Yet, the heart muscle may be able to maintain a normal circulation when the body is at rest, but when the ordinary working power of the heart muscle begins to weaken, the fatigue and dyspnea are evident, and orthopnea, anasarca, ascites, cough and pulmonary and hepatic congestion occur.

If we bear these points in mind in our study of the heart, remembering that the essential element in an efficient heart action is a normal heart muscle, we shall have taken a long step toward a comprehensive understanding of organic diseases of the heart. He who neglects consideration of these facts will absolutely fail to grasp the subject.

It is not what murmur one hears, or what valve or valves are involved, or how much hypertrophy or dilatation exists, but rather how well the heart muscle, hampered by any or several of these changes, is able to maintain a normal circulation at rest and upon exertion.

HOW TO DETERMINE THE POWER OF THE HEART.

First: If anasarca, with or without ascites, is present, if there is dyspnea on slight exertion, and if orthopnea and hepatic and pulmonary congestion exist, the reserve power of the heart is gone, and the ordinary working power is seriously interfered with.

Second: If there is no anasarca, ascites or orthopnea, the ordinary working power is fair, and may be said to be good if dyspnea does not occur on considerable exertion.

If dyspnea and fatigue do not result from walking on the level, it may be said that the ordinary working power is good, and that the reserve power is fair, but it must be borne in mind that some people who have organic disease of the heart can

walk on the level, but can not ascend a stair or an incline without marked dyspnea. Under these latter conditions a guarded judgment must be made concerning the reserve power.

If ascites, anasarca, orthopnea, cough, fatigue, or dyspnea are absent upon performing the ordinary duties required in the life of the individual, the heart may be said to be well compensated even though there be murmurs, valve defects, and hypertrophy present.

If the systolic blood-pressure increases temporarily five to ten millimeters upon exertion, without dyspnea, the heart can be said to be well compensated. If the systolic blood-pressure falls upon exertion, the heart is poorly compensated. If upon moderate exertion there is an increase in the systolic blood-pressure, and a stationary or increased pulse-pressure, the condition of the myocardium is fairly good, but if on moderate exertion there is a decrease in the systolic blood-pressure, and also a decrease in the pulse-pressure, the strength of the heart muscle is impaired.

If we find an increase in the resistance offered by the circulation and capillaries, the systolic blood-pressure will be increased, but the diastolic will not keep pace with the systolic, and, as a result, the pulse-pressure will be increased.

When the heart muscle begins to fail, the systolic blood-pressure falls, the pulse-pressure is lowered, and we have dyspnea, pulmonary congestion, enlargement of the liver, ascites, anasarca, etc.

The normal heart muscle gives a diastolic pressure twice the amount of the pulse-pressure, and the systolic pressure is one-third more than the diastolic.

TYPES OF ORGANIC DISEASES OF THE HEART.

He who attempts to make a diagnosis or a prognosis, or undertakes to treat a case of organic heart disease without having obtained a careful history of his case, will usually fail.

Excluding the goiter heart and the congenital heart, there are four types of organic diseases of the heart.

First: The type that accompanies or follows rheumatism, tonsillitis, middle-ear disease, infected teeth or sinuses, diphtheria, scarlet fever, puerperal fever, or any of the infectious diseases. In other words, that type of organic disease of the heart which is the result of a streptococcus infection and is best called the streptococcus heart.

A streptococcus infection may affect the cover-

ing of the valve flaps, partly or completely destroying their elasticity, causing them to adhere to each other or to the sides of the auriculo-ventricular ring, leaving only a buttonhole or a slit opening. Such a valve in time becomes a funnel-shaped projection into the ventricle, producing an obstruction to the flow of blood, and later permitting a leakage into the auricle. The chordæ tendinæ and papillary muscles may be involved in the inflammatory process, and the valve flaps destroyed, producing, first, an obstruction or stenosis; and, second, a leakage or regurgitation. At the same time that the valves are attacked, or soon after, the endocardium may become involved or the aortic valves become implicated, in which case their cups will become glued together, causing, first, an obstruction, and later, a leakage. In some of the streptococcus inflammations of the heart, these are the only pathological changes which occur.

If the mitral valve alone is involved, compensating hypertrophy of the right ventricle occurs together with some hypertrophy of the left. While a loud systolic murmur, with or without a presystolic murmur, may be heard, the heart becomes well compensated, and a normal circulation is maintained for many years. In fact, a normal circulation may be maintained during a long life, and the presence of an organic heart disease never suspected. But if, in addition to the involvement of the flaps and the endocardium, the myocardium is affected by the inflammatory process, and inflammatory changes occur in the structure of the myocardium, resulting in destruction of some or many of the fibers with a replacement of them by fibrous connective tissue, that heart, while it may hypertrophy and for a time maintain a normal circulation, is seriously crippled, and sooner or later, under the strain of maintaining a normal circulation, will break down and compensation will become ruptured.

If the inflammatory process extends to the parietal layer of the pericardium, pericarditis follows, which may result in a fibrous exudate and the formation of fibrous tissue. An adhesive pericarditis results, in which the parietal pericardium becomes adhered to the pericardial sac resulting in marked hypertrophy of the heart, especially the left ventricle, and pronounced dyspnea occurs on slight exertion.

The streptococcus heart is most common in the first two decades of life, but may occur at any

age. It is not infrequently associated with a streptococcus inflammation of the kidney, and an acute glomerular-nephritis follows, which may drift into a subacute or chronic glomerular-nephritis.

If these facts are remembered, and a history of a streptococcus inflammation is obtained, remembering the pathological changes possible in the heart, this type of organic disease of the heart will be readily recognized.

The prognosis of this type of heart disease does not depend upon the murmurs heard, nor upon the valves involved, but upon the extent to which the heart muscle is affected, either by actual inflammatory process, or from nutritional changes that may have occurred from the resulting hypertrophy.

THE NEPHRITIC HEART

The second type of organic disease of the heart is the *nephritic heart*, or that of the so-called cardio-vascular-renal complex.

This type of heart disease is very different from the streptococcus heart. The heart condition is secondary, and consists of two complete changes: first, the hypertrophy of the left ventricle, due to the increased resistance in the circulation, as a result of the inflammatory changes in the kidney, principally acute or chronic glomerular-nephritis; and, second, nutritional changes in the myocardium, the effect of the general nutritional changes resulting from the nephritis.

In this type of heart disease the valves are not affected, but the resulting hypertrophy and dilatation stretch the auriculo-ventricular opening, and a systolic leak occurs at the mitral valve.

As a result of the changes in the vascular system, the blood-pressure in the subacute and chronic forms of glomerular-nephritis is increased.

The prognosis depends not upon the condition of the valves, but rather upon the nutrition and integrity of the heart muscle; however, it is always grave.

THE ARTERIOSCLEROTIC HEART

The third type of organic disease of the heart is the *arteriosclerotic heart*, or the so-called senile heart.

In this type of heart disease the vascular changes are the most prominent and occur first.

The systolic blood-pressure is high. The kidney presents the characteristic findings of the

arteriosclerotic type. The left ventricle is enlarged, and this enlargement is soon accompanied by dilatation; the mitral ring leaks, and the myocardium degenerates and weakens from nutritional changes which may be due to partial or complete occlusion of the coronary arteries.

The prognosis depends entirely upon how long the heart muscle can bear the strain, unless closure of the coronary arteries takes place.

THE SYPHILITIC HEART

The fourth type of organic heart disease is the *syphilitic heart*. This type is entirely different from the other three types. The aortic arch becomes affected by a syphilitic aortitis, and inflammatory changes with dilatation occur. The arch is stretched in all directions. The aortic cups may either fail to close from retraction, or the aortic ring may become involved in the inflammatory process and ulceration or adhesion occur, either of which conditions results in aortic leakage. As a rule, the endothelium of the arch is roughened which results in a systolic murmur at the base. The left ventricle becomes hypertrophied, and from the stretching of the aorta the heart sags. In the course of time the hypertrophy of the left ventricle is accompanied by dilatation. The left auriculo-ventricular ring stretches and a mitral regurgitation results.

The prognosis depends upon the ability of the aorta to stand the strain put upon it, and the ability of the heart, hampered by such nutritional changes, to maintain the circulation.

Summary: The first type of organic heart disease, that due to streptococcus infection, affects the mitral and aortic valves causing first, stenosis, and later, regurgitation. Often the myocardium is involved in the inflammatory process, and its tissues to a greater or less extent destroyed and replaced by fibrous tissue.

In the second type of organic heart disease, the nephritic type, the left ventricle is first hypertrophied, later dilated, which stretches the mitral ring and results in a mitral leakage.

In the third type, the arteriosclerotic heart, left ventricle is enlarged, then dilated, which stretches the mitral ring, and produces a mitral regurgitation, but this type is always accompanied by a high systolic blood-pressure which usually begins to fall as the left ventricle dilates.

In the fourth type, the syphilitic heart, there exists a syphilitic aortitis, which causes a hyper-

trophy of the left ventricle, with disease of the aortic valves, resulting in aortic leakage. Later the left ventricle becomes dilated, stretching the mitral ring and producing a mitral leakage.

DIAGNOSIS.

The streptococcus or the rheumatic heart.

1. The history of a streptococcus infection.
2. The age; more common under twenty-five.
3. (A) Mitral involvement.

1. A mitral systolic murmur.
2. A mitral presystolic murmur or roll.
3. A presystolic thrill over the mitral area.
4. No presystolic murmur, with or without a thrill, but a sharp first sound.
5. A late diastolic murmur, heard best at the ensiform, or between it and the apex.
6. Enlargement of the heart downward, but more to the left.
7. A doubling of the second sound at the base.
8. Accentuation of the pulmonic second sound.

(B) Aortic involvement.

1. A systolic thrill at the base.
2. A systolic murmur at the base, which may or may not be transmitted into the carotids.
3. A diastolic murmur, which may or may not be heard at the right edge of the sternum, but is best heard at the left edge of the sternum. In rare cases this murmur is not heard.
4. Enlargement of the heart, more downward than to the left, but may also be well down and also to the left, particularly is this true if the mitral is also involved.
5. The "pistol shot" in the arteries. (Not found, if no regurgitation exists.)
6. Capillary pulsation.

First, the history.

Too much care can not be given to obtaining a careful history. Sometimes the only clue will be a history of "growing-pains" or of a slight attack of chorea. The heart trouble may remain unnoticed for years if the myocardium has not been involved in the primary infection. Again, we

find evidence of an old valvular involvement during a recurrence of a streptococcus infection, where the myocardium has escaped the first attack, but becomes involved in the second attack.

In most of the cases the apex beat can be located, especially with the patient in the left lateral prone position.

As a rule, the impulse is distinct, and a presystolic thrill is felt at the apex. Again, the apex impulse may not be strong, but rather "tappy" in character, and the presystolic thrill is distinct.

The mitral regurgitant murmur is usually distinct, and, as a rule, is transmitted to the left, and heard in the axillary space and behind, but occasionally the mitral regurgitant murmur is heard all over the chest and most distinctly at the ensiform or midway between it and the apex. The murmur may be either loud and musical, or soft and blowing, and the pitch of the murmur, if constant, gives no clue to the severity of the condition. But if a loud systolic murmur becomes soft or blowing or inaudible, it means that the myocardium has weakened. With a return of the strength of the myocardium, the murmur assumes its former pitch.

The presystolic murmur is usually heard best midway between the ensiform and the apex, but may be heard anywhere to the right of the apex, and it is not transmitted to the left. Often only a sharp presystolic roll is heard. Many times, no presystolic murmur or roll is heard, but instead a sharp, distinct first sound. This sharp first sound will come to the ear as a distinct click or sharp tap. Again, late in diastole, a murmur will be heard between the apex and the ensiform; it is sharper than the systolic murmur; it may be either high-pitched or soft, and is followed by a sharp first sound, then by the mitral regurgitant murmur.

The second sound at the base is often reduplicated. This reduplication may be transmitted to the apex. The pulmonic second at the left edge of the sternum, at the base, is distinctly accentuated out of proportion to the age of the individual, and this is a most valuable sign in prognosis. Should the pulmonic second lose its distinct accentuation, it points to a weakened or weakening right ventricle. Should it regain its pitch, it means that the right ventricle has regained some of its muscular tone.

Aortic. Remember that if the aortic valves are involved in the streptococcus infection, there is,

as a rule, first a stenosis, and later a regurgitation. As a rule, a distinct systolic thrill is felt over the base, best over the second right intercostal space. This thrill is accompanied by a systolic murmur that may not be heard in the carotids, although it may be a very loud and high-pitched murmur. The diastolic murmur may be heard at the right second intercostal space, but more frequently it is heard along the left edge of the sternum, and is nearly always soft and low-pitched; never high-pitched. Occasionally it is heard best near the apex or the ensiform.

The left ventricle is always enlarged when the aortic valves are involved, as manifested by a downward displacement of the apex into the sixth or seventh space, or under the seventh rib and somewhat to the left. If the mitral valve is also involved the apex will be well down, and in the nipple line or outside. The nipple line should be a perpendicular line drawn from the junction of the middle with the outer third of the clavicle.

The so-called "pistol-shot" may be heard in the larger arteries, but it is a diagnostic point of little importance. Capillary pulsation may be demonstrated either under the nails by holding the electric flashlight under the finger, or by placing a cover-glass on the everted lip.

If one is careful to obtain a thorough history of the case, it is almost impossible to make a mistake in the streptococcus heart.

PROGNOSIS IN THE STREPTOCOCCUS HEART.

The prognosis depends, not upon the murmurs heard or the valves involved, but first, upon the extent to which the heart muscle has become involved in the inflammatory process, and how much heart muscle has been replaced by fibrous tissue, and second, how much hypertrophy has been necessary to maintain the circulation, and to what extent this hypertrophy has interfered with the nutrition of the myocardium. In a few of these cases the myocardium escapes the inflammation, but in the majority the myocardium is involved to a greater or less extent. Then, too, the work required of the heart in each individual will influence the length of time the heart muscle can stand the strain without compensation becoming broken. When the myocardium has been involved to a considerable degree, and the heart is badly crippled, so that at the best, exertion produces some dyspnea, the prognosis is bad, and the case may develop auricular fibrillation or absolute

arrhythmia, or death may occur suddenly. In others, compensation may be broken a number of times and the heart muscle again and again take up its work, but sooner or later it fails, and death occurs. The friends should be advised of the strong probability of a sudden death which is often due to a left auricular thrombus.

We believe that women suffering with a streptococcus heart ought neither to marry and assume the responsibilities of motherhood, nor should they be permitted to do severe manual labor or any kind of labor requiring, even at times extra heart strain.

Careful tests should be made to determine the reserve power of the heart, the blood-pressure, the pulse-pressure, and the effect of exertion upon the heart for, as a rule, in a well compensated heart, one in which the myocardium is in good or fair condition, the pulse will increase upon exertion and become fuller and stronger, while in a poor myocardium, with the same exertion, the pulse will increase in frequency and become small and thready.

Every possible effort should be made to discover the location of the streptococcus infection and remove or remedy it, such as tonsils, ears, nose, teeth, antrum, appendix, gall-bladder, kidney, etc.

TREATMENT.

First: During the time of the acute attack, before compensation has taken place.

Second: During good compensation.

Third: During ruptured compensation.

Fourth: After compensation has been regained.

The first indication for treatment, during the acute attack, is the treatment of the streptococcus infection. As soon as there are any symptoms pointing to endocarditis, such as an increase in temperature that can not be accounted for, an increase in the pulse out of proportion to the respiration, some blowing murmurs in the heart, and often the feeling of something unnatural about the heart, we believe that the ice-bag over the heart is our best treatment. It should be used continuously unless there be some reason for withholding it. Care, however, must be exercised, to see that the skin does not become affected by the cold. This difficulty can be avoided by keeping the chest covered with vaseline.

Further, look after the elimination, and renew the treatment of the original infection if it has been discontinued.

Rest. It is impossible to emphasize too strongly the importance of rest in these cases. The rest must be *absolute*. The patients must not be permitted to sit up suddenly or unaided. The bed-pan must be used. The rest must be continued not only until the temperature is normal, but also until the pulse is normal. It makes no difference how well the patient feels. If rest is not insisted upon until the pulse is normal, that heart will be more seriously crippled than if rest had been enforced until the pulse became normal. If the pulse has become normal, they may be permitted to sit up in a chair for a few minutes. If, while doing this the pulse becomes increased more than ten to fifteen beats per minute, the patient should at once be put back to bed. If after sitting up twenty minutes to half an hour the pulse remains at ninety or ninety-five for several hours, the patient ought not be permitted to sit up again for from twenty-four to thirty-six hours.

In this way the patient is permitted by easy stages to be on his feet, and very slowly to walk and resume his duties of life.

If at any time the pulse remains high for several hours after any kind of exertion additional rest becomes imperative. The ice-bag may be used for an hour or two at any time, when the pulse has become increased after exertion.

Drugs. After many years of experience, the writer believes that but few, if any, true heart remedies are indicated during the acute stage of a streptococcus heart infection, but such remedies as are indicated for the general systemic infection are to be given. We believe that the majority of heart remedies do harm in this condition.

If the kidney has become affected and an acute glomerular-nephritis exists, as shown by fat and red blood cells in the urine, in addition to a variable amount of albumen and casts, small doses of some heart remedy may be given and its effects carefully observed, as, for example, two to four minims of tincture strophanthus or one-quarter to one-half grain of spartein, every two to six hours.

General Care. Keeping in mind the fact that we have a general streptococcus infection to combat, every possible attention must be given to the general nutrition. The food should be of the best and the diet well balanced and easy of digestion, as, for example, milk or, better, diluted cream, custards, well-made egg-nogs, good broths,

soups, avoiding the greasy foods as much as possible. The general anemic condition must be taken into consideration and every attention given to overcoming it.

Vaccines may be of service, but we have seen but a few cases where we believe they really did good.

Treatment During Good Compensation. When one recalls the fact that it is an impossibility for anyone, by any known diagnostic methods, to say positively whether the myocardium has been involved in the streptococcus inflammation or not or to what extent, it is a crime to permit these patients to tax their hearts until we are morally certain that full and complete compensation has occurred, and even then they must always remember that they have crippled hearts that must not be overtaxed.

These patients should report to their physician at regularly stated intervals, at which times the pulse should be taken both on repose and after exertion, the pulse pressure should be estimated and noted, inquiry should be made as to their work, habits, etc., and in case the pulse be increased beyond the normal, or if exertion produces dyspnea, rest must be enforced.

By such constant watching it is possible to keep these patients from an attack of ruptured compensation for a long time, but even in spite of our watchfulness, these hearts ultimately give way because the myocardium has become so badly crippled by the streptococcus inflammation that it can stand only a limited amount of continued work.

Keep the fact ever in mind that the prognosis in the streptococcus heart is always bad, that the probability of a recurrence of the infection is great, and that the possibility of sudden death is ever present.

Treatment During Ruptured Compensation. Oh, there's the "rub"!

In the writer's experience of thirty-four years in the practice of medicine he has never found any condition or conditions where keener judgment is necessary or more exact knowledge of the existing conditions required, than in the treatment of a streptococcus heart when compensation has become ruptured.

While we can determine most of the time, by means of auscultation, which valves are diseased, and that they are stenosed at first and later leak, yet the murmur can only to a limited extent

indicate to us what the condition of the heart muscle is.

If anasarca with or without ascites, and an enlarged liver exist, and dyspnea, orthopnea with cough and signs of some pulmonary congestion are present, we know that the reserve power of the heart is gone and the ordinary working power is badly crippled. The question is, how much work is left in the heart muscle? Will it overcome the existing acute dilatation? Will it regain sufficient tonicity to restore compensation, and how best can these things be brought about?

First: By increasing elimination by the bowels as much as the case will tolerate without too much prostration to the individual. This may be accomplished by magnesium sulphate, elaterin, calomel and magnesic sulphate, or by any method which individual experience has proven best.

Second: By skimmed milk, rye bread and fruit-juice diet. At other times by the six small, dry meals in the twenty-four hours.

Third: Venesection. Withdrawing from eight to sixteen ounces of venous blood will some times so relieve the right side of the heart as apparently to assist materially in the beginning of restoration of compensation.

When kidney compensation is ruptured by passive congestion, such as we have in this class of cases, it is a grave question whether diuretics of any kind do good until after the heart muscle begins to regain its tonicity. They may be tried, but our own experience is that they do no good.

After the pulse begins to be slower and increases some in volume, and after there is some increase in the amount of urine, then diuretic, theocin, or any diuretic of known activity, may be used.

Heart Remedies. As has already been stated, the writer believes that no heart remedies whatever should be given until elimination has been increased and rest secured.

It may be necessary to use morphin, or morphin and strychnin combined. Sufficient morphin should be given to relieve the dyspnea, quiet the nervous system and secure rest.

If we were sure in each case that the heart muscle would stand it, heart remedies might be given, but we are never sure; therefore, rest, the ice-bag, diet, with increased elimination, first, gradually followed by the heart remedies.

Strophanthus, tincture, two to four minims,

every two to four hours, or spartein, one-quarter grain to one-half grain every two to four hours, until elimination has been increased, the dyspnea somewhat relieved and the pulse slowed to some extent. Then digitalis is, we believe, the remedy, using sufficient of the drug to slow the pulse. As soon as the pulse approaches the normal, reduce the dose of the drug, and give only a sufficient amount to hold the pulse at or near the normal. If digitalis does not slow the pulse perceptibly in seventy-two hours, it is either a poor preparation or it will do that particular case no good.

Strychnin, 1/60 gr. to 1/40 gr., t. i. d., is always a good remedy, not for its action on the heart, but for its effect upon the central nervous system.

As soon as the pulse begins to approach the normal, as has been suggested, diuretics may be given, and, if necessary, pushed; diuretic, theocin, potassium acetate, following these three by one to two dram doses of elixir of pepsin or some digestive aid. In the writer's hands, calomel has proven a most valuable diuretic in these cases. Care, however, must be exercised to know positively that no acute glomerular-nephritis exists before it is used.

It has been our custom to use the magnesium sulphate in a saturated solution, administering the required amount in black coffee, orange juice or grape juice. If anasarca is severe, a saturated solution of magnesium sulphate by the Murphy drip method is well worth using.

The diet should be salt-free, the amount of liquids limited, and occasionally, in desperate cases, strophanthine, 1/250 gr. to 1/200 gr., should be administered intravenously. Great care must be exercised to be sure that it enters the vein and not the surrounding tissue.

As soon as the heart muscle has regained its tonicity to a fair degree, some exercise may be permitted, watching the effect on the pulse carefully.

If auricular fibrillation, or absolute arrhythmia occurs, then digitalis is the remedy, pushed as far as is necessary to restore some regularity.

The same care must be exercised in the recovery from a broken compensation as is given during the acute attack.

Treatment After Compensation Has Been Regained. Each time compensation is broken, in a streptococcus heart, it requires a longer time for the heart muscle to regain its tonicity, and

in all probabilities when compensation is once ruptured, the heart muscle never fully regains its previous tonus.

After compensation has become re-established great care must be observed in the amount of exercise the patient is permitted to take. An hour or two of rest in the middle of the day should be insisted upon, and the effect of exercise on the breathing carefully watched. Any signs of dyspnea or of anasarca call for additional rest.

For years we have insisted upon our patients suffering from streptococcus heart who have had a broken compensation, remaining in bed one day each week, and when it has been possible have ordered them to a warm climate during the cold months. Special attention has been given to the diet, a careful, well-balanced diet planned, with an endeavor to prevent overweight or even to keep them somewhat underweight, if possible.

Should some slight dyspnea occur on exertion, digitalis, strophanthus or spartein is given for a few days.

Special care is given the bowels, the habits are inquired into and an endeavor is made to have these patients live as methodically as possible, avoiding all kinds of excitement. They are frankly told of the danger of over-exertion, and that, while moderate exercise is permissible, it must be done guardedly.

It has been our observation that people suffering with crippled hearts as a result of streptococcus infection require more careful and skillful handling than any other class of medical cases. We are sure that many serious mistakes are made in handling such cases through lack of appreciation of the importance of a thorough understanding of the pathological changes that have occurred in the heart. While a few of the patients escape without serious involvement of the heart muscle, by far the great majority have a badly crippled heart muscle, one that can not stand the work required of it for very many years, at best. If the findings point to an undoubted streptococcus heart, the prognosis must be guarded and the patient and family frankly told of the gravity of the condition. It must also be impressed upon these patients that their best chances of prolonging their lives lie in their placing themselves under the care of some physician in whom they have utmost confidence, consulting him at stated intervals and following his advice implicitly.

It also behooves the physician to realize fully

the gravity of the condition and, no matter how busy he may be, to give these people, each time they present themselves for examination, a careful and thorough looking over, noting each of the following points, namely: The size of the heart, the pitch of the murmur, the effect of exertion on the systolic blood pressure, the pulse pressure and the breathing, keeping a careful record of the findings of each visit.

PERICARDITIS ACCOMPANYING THE STREPTOCOCCUS HEART.

No pathological condition of the heart is more difficult to diagnose positively than pericarditis.

If, in a case of streptococcus involvement of the heart, where the temperature has remained stationary for some days, there is a sudden increase in the temperature with pain in the chest, some increase in the dyspnea, or dropsy, or if, where dyspnea has not previously been present, it occurs, and pain is referred to the heart, a to-and-fro friction murmur is heard that is apparently close to the ear, a diagnosis of pericarditis can be made, but the number of cases that present these clinical symptoms is exceedingly small. As a rule, the only symptom will be an increase in the temperature, with perhaps some increase in the dyspnea, or the occurrence of dyspnea alone, and this symptom is not constant.

If effusion occurs and it be of considerable amount, the liver angle may become changed, the heart sounds may be missed and signs of lung compression may be present, especially behind. If the exudate is fibrous, the amount may be small and consequently no signs can be obtained.

Adhesive pericarditis cannot be diagnosed unless the adhesions become sufficiently strong to interfere with the action of the left ventricle. If the adhesions existing between the pericardial layer of the heart and the lining of the pericardial sac are strong enough to interfere with the action of the heart, the left ventricle may become enormously hypertrophied and have an impulse which is heaving in character. The most valuable diagnostic point, aside from the x-ray, is the fact that while the heart is large and apparently well compensated, marked dyspnea occurs on slight effort. Again, the heart may be adhered to the pericardial sac, the pericardium to the diaphragm, and the inflammatory process extend through the diaphragm to Gleason's capsule of the liver, in which case ascites occurs without anasarca—a rare condition.

Treatment. We know of no better treatment

for pericarditis than the ice-bag for the acute attack, and whatever remedies may be indicated for the primary streptococcus infection.

There is no treatment for adhesive pericarditis.

MALIGNANT MYOCARDITIS.

This condition, fortunately, is not common, but when it does occur is very fatal and exceedingly difficult to recognize.

If, in the course of streptococcus involvement of the heart, the temperature remains high or fluctuates, the patient presents the appearance of a septic case, the leukocyte count is high, the red cells give evidence of a secondary anemia, and the heart sounds are weak or even of the so-called "tick-tack" heart variety, malignant myocarditis may be strongly suspected.

The only treatment is that of the general septic condition.

THE NEPHRITIC HEART.

Attention has already been directed to the possibility of the streptococcus attacking the kidney and heart at about the same time, the kidney lesion being an acute glomerular-nephritis. The greater number of these cases will be in the streptococcus age, although an occasional case will follow puerperal infection. The urine will contain albumin in varying quantities and casts of all kinds, but of especial diagnostic value is the presence of fat and red blood cells. Dropsy is usually present to some extent and may be extreme, especially near the close of the case. The patients are anemic, the blood pressure may be increased from twenty to one hundred millimeters of mercury, or even higher, while no such increase in the systolic blood pressure occurs when the heart alone is involved. The left ventricle soon becomes enlarged, the aortic second becomes accentuated and may be ringing in character, the apex becomes displaced downward and the impulse is distinct and often heaving in character. Such a picture often follows an attack of perperal septicemia, but so long as the left ventricle is able to maintain the systemic circulation without stretching the left auriculo-ventricular opening, no murmurs are heard, but the aortic second is accentuated at the second right intercostal space, with signs of hypertrophy of the left ventricle. When the left auriculo-ventricular opening becomes stretched, a mitral systolic murmur is heard in the mitral area, transmitted more or less to the left. This murmur is never high pitched, but is soft and blowing; there is never any thrill or

sharp first sound. When the mitral begins to leak, signs of pulmonary congestion occur, as cough, dyspnea, orthopnea and hepatic congestion, together with ascites sooner or later. The blood picture is one of secondary anemia.

If the reader still adheres to the classification nomenclature of chronic interstitial nephritis, where the urinary findings are a fixed specific gravity, with albumin and hyaline and granular casts, together with an increase in the systolic blood pressure (to one hundred ninety or more), accompanied by changes in the coats of the arteries, then the heart findings in such a case should be classed under this second type of organic diseases of the heart. The left ventricle is enlarged, the aortic second is accentuated, and with dilatation there occurs a relative mitral regurgitation. The writer classifies this type of kidney as an arteriosclerotic kidney.

Diagnosis. The history of a streptococcus infection.

The urinary findings, especially the fat and red blood cells.

Enlargement of the left ventricle.

No systolic thrill at the base.

As a rule, no systolic murmur at the base, but there may be a slight roughening with a sharp murmur.

No diastolic murmur.

Accentuation of the aortic second, at the second right intercostal space, often ringing in character.

No presystolic thrill at the apex.

No sharp first sound at the apex.

No presystolic murmur or roll at the mitral area.

A mitral systolic murmur, soft and blowing in character, transmitted to the left.

Prognosis. If a glomerular-nephritic is present which, as we believe, is the only cause for this type of organic heart disease, the majority of the patients die during the acute attack, in spite of any treatment that may be used. Occasionally one lives for from one to three years, with a gradual increase in all the symptoms, and eventually dies from heart failure. Occasionally, in a great number of cases, one lives longer and drifts into a condition of true arteriosclerotic kidney and may live for years, but the prognosis is always bad.

Treatment. No treatment is known that will have any effect upon the kidney. There are three indications for treatment:

(A) Attention to the heart.

(B) To guard as well as possible against uremia.

(C) Attention to the general condition, anemia, etc.

For the heart, the writer believes digitalis to be the best drug at our command. If the pulse pressure is falling and signs of pulmonary and hepatic congestion are present, enough of the drug may be given to slow the heart's action and relieve the dyspnea. Other heart remedies may be used, if preferred.

Insomnia is a common symptom and must be given attention. Some opiate may be necessary, such as heroin, 1/20 gr. to 1/12 gr., hypodermically, at night, or, what the writer has found to be excellent, a combination of 1/50 gr. of apomorphine and 1/20 gr. heroin, hypodermically. Codeine or even morphin may be required, but do not use the coal-tar derivatives. Our experience has been that the bromides do no good.

Push the elimination as much as the patient can stand by means of magnesium sulphate, elaterin, hot packs, hot air baths, etc., anything that can be done to prevent uremia.

For the general condition attention to the diet, making it salt-free, or practically so, limiting the amount of protein, administering plenty of fruit juices, and adjusting the liquid intake to the liquid output, or a little above the output, are helpful. Iron, quinine and strychnin are drugs that may be found useful.

THE THIRD TYPE OF ORGANIC HEART DISEASE.

(The arteriosclerotic or the senile heart.)

Contrary to the general belief, arteriosclerosis is not confined to old age, while true atheroma may be said to be a disease of the aged. Arteriosclerosis in some stage is found often at an early age, and consists of distinctive changes in the arterial walls, with a distinct syndrome. The arterial changes may be slight, but they are sufficient to cause the characteristic concurrent changes in the heart and kidneys. In no other class of organic diseases of the heart are so many mistakes made in diagnosis, prognosis and treatment as in this type, and in no other type of heart disease can so much be done to give relief. If the fact that the arterial changes are the first to occur and that these changes affect the arteries of the kidneys as well as those of the rest of the body is kept distinctly in mind, this type of

organic heart disease will be much better understood.

Urinary Findings. One of the earliest symptoms, if not the first, is nocturia. When no other cause exists, such as prostatic irritation, etc., the night urine will equal in volume, or exceed, that of the day urine. It may contain casts, hyaline and granular, but soon the most distinctive finding shows itself, namely, the fixed specific gravity which may be either low or fairly high, depending upon the amount of area excreted.

Vascular Changes. The arterial walls may be thickened and the pulse may be either small or full and strong. The arteries may be tortuous. The systolic blood pressure is high, 180 to 250 millimeters of mercury or higher. During the period of good heart compensation the diastolic pressure will be in proportion to the systolic, and the pulse pressure will be practically normal for the individual, but when the heart begins to stretch, both the systolic and diastolic pressure will fall, but the diastolic not so much as the systolic, thereby leaving the pulse pressure below normal.

Heart Findings. In the majority of cases no heart symptoms are manifest for years. The first symptoms may be fatigue, with some dyspnea on exertion, even on exertion that the individual has been accustomed to take without difficulty for years previous. Again, the first heart symptom may be an attack of angina, which may be slight or severe.

Upon examination two distinct varieties of this form of organic heart disease are identifiable, and upon the accurate differentiation of these two varieties depends success in treatment and the patient's comfort and length of life.

First: If the patient is comparatively young, thirty-five to fifty-five, and has been engaged in indoor work or light work, and if, for various reasons, the general nutrition has not been good for some months, these individuals notice that they are fatigued more easily than formerly and have some dyspnea; then they have an attack of angina which compels them to consult a physician. Upon examination the pulse is found to be increased in frequency and small in volume. The left ventricle is enlarged, the aortic second is somewhat accentuated, and a distinct systolic murmur is heard at the right base. This murmur may be sharp and short. It is never loud, like that found in aortic stenosis from streptococcus infection. A soft, blowing mitral

systolic murmur is heard at the apex, which is not transmitted far to the left.

Such a heart is not properly compensated to stand the work required of it in maintaining a normal circulation, working against an arterial system whose caliber has been to a greater or less extent narrowed.

To give such patients vaso-dilators, as the nitrates, aconite, or veratrum, to relieve the angina and lower the systolic blood pressure is a serious mistake. Such patients require increased elimination, a restricted diet and enough digitalis to slow the heart so that the heart muscle will receive a better blood supply as a result of the coronaries being filled when the recoil of blood occurs in the aorta. If this treatment is followed for some weeks the nutrition of the heart muscle is improved, the left ventricle increases in size, the contraction of the heart is better, the systolic murmur at the base becomes more distinct, the aortic second sounds sharp and snappy, the mitral systolic murmur at the apex disappears and for years that individual lives a comfortable life. As time goes on, unless he dies from some other cause, he will eventually present the symptoms of the second type of this variety of organic heart disease.

The story of the second variety of this type of heart disease is quite different. They are older—fifty-five to seventy-five. There is marked arteriosclerosis. All the urinary findings characteristic of the first variety are present in an exaggerated form. There is some anasarca of the ankles, the shins, and even up to the knees, at night. Fatigue and dyspnea upon exertion are marked. The mentality is slow, the memory for long past events better than for recent events. Some orthopnea may be experienced and is often marked, and signs of pulmonary congestion may be present. The arteries are tense and show marked evidence of a sclerotic condition. The systolic blood pressure, which has been quite high previously, has come down some, while the diastolic pressure has increased and the pulse pressure has lowered. The aortic second, while still markedly accentuated, has lost some or all of its ringing tone. Attacks of angina may be, and quite frequently are, severe. The apex impulse has lost its heaving character, the heart has sagged further down. The systolic murmur at the base is not so loud; the mitral systolic murmur, soft and blowing in character, is heard

at the apex and is transmitted somewhat to the left.

In this variety of cases secondary changes have taken place in the heart muscle. The hypertrophied left ventricle has dilated, as has the whole heart, to some extent. The coronaries are partly occluded, and as a result marked nutritional changes have taken place in the heart muscle.

While digitalis in small doses is indicated for such a heart, it can do but little good and will not add any to the length of life. While in the first variety the vaso-dilators were contra-indicated for the anginal attacks, in this variety they are imperative.

The writer's method has been to use, for immediate relief, amyl nitrite, or 1/200 gr. to 1/150 gr. of nitro-glycerin tablets under the tongue. But to prevent, if that be possible, or at least to relieve, the severity of the anginal attacks, aconite in small doses, or veratrum in small doses, has given better results. The elimination must be increased as much as possible, and the intake of fluids and salt restricted, but eventually the heart will dilate and death will follow. These patients may have repeated attacks of spasm of the cerebral arterioles, resulting in aphasia, or even partial or complete hemiplegia, lasting for a few days. Further, true cerebral hemorrhage may occur, and death or permanent paralysis follows.

Summary. Two varieties of arteriosclerotic heart.

First: Comparatively young. High blood pressure. A systolic murmur at the base. A mitral systolic murmur at the apex. An accentuated aortic second. The mitral systolic disappears under proper treatment.

Second: Past middle life. High blood pressure has existed for years. The systolic pressure has decreased to some extent. The diastolic has increased. The pulse pressure has diminished. The systolic murmur at the base may be present or may not. Aortic second has been markedly increased for years. When the systolic blood pressure lowers the aortic second becomes less pronounced. A mitral systolic murmur is heard at the apex.

Vaso-dilators are not indicated in the first variety, but are required in the second. Digitalis should be given in sufficient doses to accomplish

compensation in the first variety; in small doses in the second.

FOURTH TYPE.

The fourth type of organic disease of the heart is altogether a different story.

It rarely begins before forty, is present occasionally at thirty to thirty-five, and is most common at forty-five to fifty.

It is always due to syphilis. If the reader will keep this fact in mind it will assist very materially in understanding the changes present. As a rule, it will begin fifteen to seventeen years after the primary syphilitic infection. If the patient is from thirty-five to fifty, usually the first symptoms to show themselves are fatigue, with some dyspnea upon exertion, coupled with anginal attacks. The blood pressure is not high except as will hereafter be noted. No abnormal urinary findings are present, unless there be found an occasional waxy cast. The first intimation the patient has that there is anything seriously wrong with him is an attack of angina, with pain in the arm or arm and chest. The examination of the heart may reveal nothing but some misplacement of the apex downward, with a suspicion of a systolic murmur heard at the base and a systolic murmur present at the apex.

What is the pathology?

The syphilitic infection of the aorta has produced a syphilitic aortitis, with some roughening of the lining of the arch of the aorta, some dilatation, and some retraction of the aortic flaps. The coronaries do not fill properly, and the heart has not hypertrophied sufficiently to compensate for the increased caliber of the aorta and maintain a normal circulation.

Digitalis in small doses will do these patients good and add years to their lives, but unless the disease is recognized at this time through a carefully investigated history and the finding of a positive Wassermann, and unless radical anti-syphilitic treatment is instituted, the inflammatory condition of the aorta continues, the aortic ring may be stretched, the aortic cups may be ulcerated, retracted or adhered to the walls of the aorta or to themselves in such a way as to imperfectly close the openings; the left ventricle hypertrophies and the heart sags downward.

Upon examination we find the aortic second at the base is often lost or but feebly heard. As a rule, a systolic murmur is heard at the second right space, while along the left edge of the

sternum, especially at the third, fourth, fifth intercostal space and at the ensiform, we hear a soft diastolic murmur. As time goes on the dyspnea becomes more marked, and pronounced signs of extreme anemia are often present. The x-ray furnishes evidence of the enlarged arch. With a sagging heart, the trachial "tug" may be present, together with signs of lung compression, brassy cough, inequality of the radial pulses, evidence of pressure, as swelling on the left arm, signs of lung compression in the back, with, many times, a marked systolic and diastolic murmur. Occasionally the syphilitic infection not only involves the aorta, but also extends to a considerable extent along the large arterial branches, and not infrequently invades even arteries of comparatively small caliber. The aorta, while it is dilated, does not assume the aneurysmal type, and the decreased arterial caliber raises the systolic blood pressure to some extent, as some arteriosclerosis may co-exist. Such a condition is likely to be confused with the arteriosclerotic type of heart, but the urinary findings are so different that but little difficulty should be experienced in differentiating the two conditions. Then, too, the arteriosclerotic heart never has a diastolic murmur, except when it occurs late in life. If a diastolic murmur is found in an arteriosclerotic heart, the urinary findings are of great value in differentiation.

Diagnosis. First: The history, with a positive Wassermann.

Second: Enlargement of the heart, with sagging, which should be confirmed by the x-ray.

Third: A systolic murmur at the base, due to roughening of the arch.

Fourth: A diastolic murmur at the left edge of the sternum.

Fifth: Either no increase, or but little increase, in the systolic blood pressure, as a rule. If the systolic blood pressure is increased, the urinary findings will assist in the diagnosis.

Treatment. No known treatment can insure a cure for these cases. Anti-syphilitic treatment may do some good in prolonging life. Digitalis will help to sustain the heart to a certain extent, but no promises must be made. Attention to the general condition, with whatever vaso-dilators are necessary for the relief of the angina, and a warning against over-exertion should be given.

(To be Continued.)

TERTIARY SYPHILIS OF THE NOSE AND THROAT.*

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Tertiary lesions of the upper air passages occur not so infrequently but that they should be readily recognized by the general practitioner, who usually is the first to see them. This statement, however, presupposes the fact that the physician does see them, and herein lies the rub. Very often the lesion is overlooked through carelessness in the examination, and even a suspicion of the true nature of the affection is lacking.

These lesions, when discovered early, are very amenable to treatment, and the results obtained in most cases mean complete restitution of structure and function. When undiscovered and untreated, however, they lead to dire results, such as destruction of important tissues, deformity and loss of function. Nothing is more distressing, both to the patient and his associates, than a saddle nose, a large perforation of the septum with crust formation or a perforated palate with the attendant voice impairment and expulsion of food through the nose. While it is true that cases of extreme loss of tissue are not seen as frequently as formerly, this fact should be attributed rather to our modern methods of intensive treatment in the earlier stages of the disease than to any particular acumen in the diagnosis of such cases as do reach the tertiary stage. Yet among the latter are many that are frequently undetected and therefore improperly treated, thus exposing the patient to irreparable harm.

The trouble lies in two directions. First, the primary lesion antedates the present complaint by so wide a stretch of time that the connection is lost sight of by both patient and physician. In many instances where the true nature of the trouble is brought to light the patient is firm in the belief, often on the authority of a former physician, that he had been cured. Second, the physician either neglects to make a thorough examination or, having examined the patient, fails to see the lesion. It is regrettable but nevertheless inexcusable, that so many physicians are not in the habit of making a careful examination of the nose and throat as a routine measure in all cases with head symptoms, and there-

fore lack the evidence which direct inspection affords.

Tertiary lesions may appear anywhere along the upper respiratory passages from the vestibule of the nose down to the subglottic space in the early form either as a gumma or a chondritis, and later as an ulcer which is either circumscribed, deep and destructive, or else superficial and serpiginous. They are most frequently found on the bony septum of the nose, the hard or soft palate, posterior wall of the pharynx, epiglottis and its folds.

A gumma of the septum, when seen early, appears usually over the vomer as a smooth circumscribed swelling covered by a generally inflamed mucosa. It may be mistaken for a septal deflection, but should be differentiated from the latter by the absence of the angularity which characterizes most deflections, as well as the lack of the usual concavity of the opposite side of the septum. Often the swelling is bilateral and may resemble a hematoma, from which, however, it is differentiated by the history of an indefinite onset, absence of trauma and the localization of the swelling. Hematoma of the septum produces a more diffuse bilateral swelling, taking in the cartilaginous as well as the bony portions. An abscess of the septum of non-specific origin is to be differentiated from gumma by its more acute onset, often the result of trauma, greater diffusion of the swelling and the fluctuation which can always be elicited. Neoplasms, such as chondroma, osteoma and fibroma, are more firm in consistence, irregular in outline and of slower development. Gummata of the septum usually produce marked nasal obstruction, profuse mucous discharge and frequently headache. Later the masses break down and an ulcer appears, which has well-defined margins and is covered by a sloughing membrane. Finally, a perforation of the septum results, which in the final stages leads to external deformity. The headache is more or less constant and there is a foul, profuse, mucopurulent discharge.

The same lesions may be found in the pharynx and palate. The symptoms usually complained of are loss of appetite, earache, sensation of a foreign body in the throat and at times regurgitation of food through the nose. Pain, though frequently severe, is often slight or entirely absent and, therefore, not a symptom of any great value. Gummata are not seen as frequently in

*Read before Jackson Park Branch, Chicago Medical Society, Dec. 19, 1918.

the pharynx as in the nose or hard palate, probably because they tend to break down earlier through the muscular activity of swallowing and speaking as well as the pressure of the food bolus passing the fauces. It is possible for the resultant ulcers to be mistaken for Vincent's angina. They lack, however, the intense inflammatory reaction and the accompanying lymphadenitis which so characterize the Vincent lesions. The bacteriologic and serologic examinations in case of doubt make the diagnosis very easy.

Gummata of the larynx may be found on the epiglottis and its folds, over the arytenoid cartilages and the ventricular bands. They must be differentiated from a beginning malignancy which in some cases is difficult. If the Wassermann is doubtful or negative a portion should be excised for microscopic examination. As a rule, carcinomata occur in much older patients than do the gummata; they are of slower development, of firmer texture and give rise to more pain. Tertiary ulcers of the larynx are often unaccompanied by pain except when located on the epiglottis or the posterior surfaces of the arytenoids. Pain develops later as the perichondrium becomes inflamed and necrosis sets in. These ulcers may be mistaken for tubercular or malignant lesions. In the case of tuberculosis one usually finds the accompanying pulmonary lesions or a history of the same. Locally there is a marked pallor in contrast to the congestion about syphilitic ulcers, the ulcers are more shallow and irregular and there is usually the characteristic chronic edema of the epiglottis and ary-epiglottic folds. Extrinsic malignant ulcers are more painful than syphilitic and frequently accompanied by hemorrhages and swelling of the cervical glands. It must be pointed out in this connection that intrinsic carcinoma of the larynx is rarely accompanied by pain or swelling of the cervical glands. These symptoms when they do appear are indicative of an advanced stage of the disease.

The usual symptoms of tertiary lesions of the larynx are dysphagia, husky voice, brassy cough and profuse expectoration of mucus.

The following case histories will serve to illustrate some of the varieties above mentioned and will demonstrate how mistakes in diagnosis may be made.

Case 1. Mr. D. D. Aged 44 years, single. Two months ago noticed a swelling in the throat and

difficulty in swallowing. Later he suffered much pain and was troubled by the accumulation of considerable mucus in the throat. He was treated by various local measures without result. The physicians who referred him thought it was a case of sarcoma. Examination disclosed a soft boggy mass in the right lateral pharyngeal recess extending above the level of the soft palate. On the posterior wall of the pharynx on a level with the epiglottis was an ulcer the size of a dime, of punched out appearance, with regular margins and covered with sloughing granulations which the physician had failed altogether to see inasmuch as it was not visible on the ordinary depression of the tongue and was brought to light upon using a laryngeal mirror. The patient denied venereal infection and had no recollection of any primary lesion. Smears were negative to the Vincent bacillus and spirillum. The Wassermann was strongly positive. Specific treatment brought about a complete disappearance of the lesions within four weeks with a minimum of scarring at the site of the ulcer.

Case 2. Mr. B. H. Aged 27 years, single. Complained of hoarseness for several months past following overheating at a dancing party. There was no pain or cough. He had been treated with some internal medication without result. No examination of the larynx had been made. The family history was negative. Personal history disclosed the fact that several years ago he had had a sore on the penis which had never bothered him sufficiently to have it treated. It had disappeared spontaneously. Examination showed a reddened epiglottis, right arytenoid slightly swollen and inflamed and a small ulcer on the right vocal cord at its middle third which was covered with a yellowish slough. Movements of both cords were unimpaired. The Wassermann was strongly positive. Under specific treatment the lesions yielded promptly and the ulcer was completely healed in six weeks.

Case 3. Mr. E. R. Aged 44 years, married. Father of two children, aged 17 and 9, in good health. Wife living and well. Previous history as to venereal disease negative. Had a severe "cold in the head" beginning about six weeks previous which was unsuccessfully treated by an internist of good repute. The throat had been examined but not the nose. Examination shown a smooth swelling of the septum extending into both sides about the level of the inferior border of the middle turbinates and closing both middle meati. The mucosa was inflamed and the mass yielded slightly to pressure. The soft palate had a doughy appearance, was swollen and did not react to stimuli. Behind the posterior pillar on one side was a deep sloughing ulcer extending from the pharynx laterally to the pillar and encroaching slightly on the tonsil. The patient was positive he had never been infected with syphilis. The Wassermann was strongly positive. Specific treatment brought about a complete absorption of the septal gumma, restoration of the function of the palate and healing of the ulcer with a shallow cicatrix.

Case 4. Mr. J. G. Married. No children; wife

living and well. Four months ago the patient had a "cold in the nose." There was swelling at the base of the nose and tenderness lasting three weeks. Lately there has been a thick discharge from the nose with scab formation. Also for several weeks past there has been an eruption on one auricle. Examination disclosed a small pustule on the septum just within the vestibule. On being pierced it led into a fistula running into the septum for a distance of an inch and ending in an ulcer about the size of a quarter. The septum was swollen into a contact with the inferior turbinates. On the right auricle there were a number of small pustules. Previous history of a chancre the years ago. Was treated by a G-U man for one year and pronounced cured. The Wassermann was strongly positive. Specific treatment cleared up the ear lesions within a week. The gumma of the septum was absorbed in three weeks and the ulcer healed in two months leaving a deep scar but no perforation.

Case 5. Mrs. H. A. Aged 56 years, widow. About a month ago had a sore throat and pain in the right ear. Was treated by two physicians and was given various drops to put into the ear and gargles for the throat but without effect. The throat had been inspected but not the nose or ear. Lately her speech has become thick and she has noticed regurgitation of liquid foods through the nose. Previous history of smallpox in childhood and "peritonitis" a few years ago. Husband died about twenty years ago of unknown cause. She has had several abortions. One child living and in good health. The right auditory canal was filled with a soft caseous material. This was removed and the canal and drum membrane were found intact but very much engorged. The soft palate was thickened, particularly to the right of the median line. The uvula was broad and red. On lifting the soft palate a deep ulcer was seen extending from the posterior wall of the nasopharynx around laterally to the right and over to the upper surface of the soft palate. It was covered with a gray slough. Examination of the nose disclosed nothing abnormal. The ulcer in the nasopharynx could be seen through the nose after the turbinates had been shrunk with adrenalin. The Wassermann was strongly positive. Specific treatment brought about a prompt resolution with restoration of function and a minimum of scarring. A tiny perforation of the soft palate remained.

These and similar cases are of value as pointing out the vast importance of the local examination, for only by inspecting the lesions does one come upon the suspicion that the case may be one of syphilis. Physicians should be more proficient in the use of the head mirror, an art that can be readily acquired with a little patience and practice. Through routine examination of the nose and throat in all new cases any physician can easily attain sufficient skill to enable him to

make out pathologic changes in these narrow passages. Once the lesion is seen, whether its true nature is recognized or not, it will lead to the taking of the Wassermann and thus frequently spare the physician the chagrin at having failed in his diagnosis as well as the patient the possible disastrous results of his error.

25 East Washington Street.

SHALL WE DEVELOP CUSTODY OR
RESEARCH FOR CURE AND PRE-
VENTION?—ONE CENT FOR RE-
SEARCH ON EVERY DOLLAR
FOR CUSTODY

BAYARD HOLMES, M. D.

CHICAGO

There is now in the custody of the asylums and hospitals for the insane in the United States a larger number of citizens than the total casualties in our army overseas. Of this 250,000 insane, 140,000, at least, are dementia praecox patients.

In recent statistics from the State of New York, with 35,213 insane of all kinds, 18,940, or 53.81 per cent, were cases of dementia praecox, but only 21.4 per cent of the annual admissions are victims of the insanity of adolescence. During a period in which 21,070 cases of dementia praecox were under care of state hospitals in New York, 21, or 1 in 1,000, were discharged recovered, and 852 died. The average age at death was 50 years, the death rate per thousand 40.4 and the stay in hospital after commitment 16 years.

These are the statistics of Horatio M. Polloch of the New York State Hospital Commission, who remarks in closing his article: "*A hundred thousand dollars a year might well be spent in learning how to prevent and cure a malady that now involves direct and indirect losses to the State of more than ten million dollars a year.*"

Unfortunately, statistics for the forty-eight states are not available. The problem, however, is put before us by Polloch's article¹, and in our State Institutional Quarterly, which ought to be on the table of every alert physician and patriotic citizen in the State of Illinois.

OUR PROBLEM IN ILLINOIS

The Department of Public Welfare proposes to increase the custodial institutions of the State

1. Dementia Praecox Studies, July, 1918, Vol. I, pp. 149-152.

by adding an institution for the feeble minded at a cost of a million and a half. A new appropriation must be made to support the epileptics who are clamoring for admission to the new and vacant institution at Dixon. This cannot be less than \$200 a year for 2,000 epileptics, or \$400,000. There are many feeble minded who are social disturbers, if not criminals. They must be provided for separately. These are all important provisions.

OUR LESSON FROM THE PAST

The handicapped, mentally, morally and physically, are the human waste of civilization. Smallpox, one hundred and fifty years ago, killed one out of every fourteen born in Europe and left half the remainder pock marked and morbid, reducing enormously their industrial efficiency and joy of life. With the increasing productiveness of labor, due to the steam engine and dynamo, and the concentration of population in buildings and conveyances, tuberculosis decimated and undermined the industrial army. Prevention of this waste was made possible by the discovery of Koch. The great need of tropical products and commerce with the tropics multiplied with the increasing concentration of population in the cities. Interruption from epidemics of yellow fever and plague by quarantine, by death, by morbidity and by terror made the scientific study of these diseases economically necessary. Walter Reed, Carroll, Lazear, Agramonte and a group of volunteer American soldiers demonstrated in 1900 the clinical deductions of Charles Finlay in 1881; and William C. Gorgas and the Panama Canal Commission practically exterminated the motive of quarantine and made the building of the canal an uncomplicated engineering problem. Kitasato and Yersin were the discoverers of the bacillus of plague, but the life history of the disease and its relation to rats, squirrels and other parasites came at the end of the nineteenth century. Yellow fever was a commerce borne epidemic of the Atlantic, while the plague was centered about the China sea and was carried by trade in every direction. Typhoid fever was a terrible epidemic in city and country where population became at all dense. It was clinically recognized a hundred years before its pathological cause was discovered, in 1880, and twenty-five years later the possibilities of rational scientific control were demonstrated in the Japanese army

in Manchuria. The morbidity by this disease was reduced to 4 per cent of the total morbidity. Almost equal sanitary extermination has been secured in the most civilized cities. Immunizing the exposed was demonstrated by Leishman in South Africa in 1908 to be promising, but the prevention by inoculation was made complete in the American army on the Mexican border in 1915. Then 100,000 men were immunized and kept in an infected region for many months with only thirty-three cases and scarcely a death from typhoid alone.

When these facts have been used as an argument for research looking toward the discovery of the causes and the possible cure and prevention of the insanity of youth, the directors of two state and one private psychiatric institution have demurred at the presumption of any parallel between smallpox, yellow fever and malaria on the one hand and dementia praecox and manic-depressive insanity on the other. That was some few years ago, when their *excathedra* bulls produced on the enquirer as much intellectual paralysis as they did emotional consternation. At Kankakee, at Ann Arbor and at Johns Hopkins, to which a distracted parent went for rational relief for a sudden and indubitable dementia praecox, the answers were the same. These leaders of psychiatry offered no hope through research. It is our contention that so-called mental diseases are subject to the same sort of study and interpretation as the mental symptoms of smallpox, typhoid, alcoholism or Spanish influenza.

RETARDATION IN PSYCHIATRY

The method of Sydenham was the clinical method. The end of that method is a clinical diagnosis, a clinical etiology and symptomatology and a post-mortem pathology of the disease. By this method all diseases are first recognized and studied. The mental diseases have long been studied by the method of Sydenham. The classifications of alienists are based on this primary method. These classifications have changed so rapidly during the past fifty years that the average practicing physician does not know the latest fads, and the historian of psychiatry cannot predict the next to come. The total diagnostic armamentarium of the alienist of today differs from that of one hundred years ago in no essential particular. Only after general paresis has been symptomatically discovered are the blood and

spinal fluid examined to confirm the presence of syphilis.

In pathology the method of Roketansky, Virchow and Hirshfeld was contemporaneous with the method of Sydenham. It was supplanted, or at least supplemented, by the method of Pasteur, Koch, Klebs, Lister, Ehrlich, Adami and a great army of investigators. Surgery, medicine and most of the specialties of late years have neglected the method of Sydenham and placed too exclusive reliance on the laboratory methods. This is not the case, however, with the psychiatrists. They still multiply observations, symptoms and post-mortem morphology.

The First Step Forward in Psychiatry.—In Psychiatry, however, one disease or condition has passed out of the realm of mystical etiology into a rational pathogenesis. General paresis is now cerebral syphilis. It can be recognized by objective findings, both clinically and at autopsy, regardless of conduct symptoms, mental deviations or psychosis of any sort, and sometimes when these ancient diagnostic symptoms do not exist. This etiology was inferred by the clinical method, but was vigorously denied to the very last by a large minority of alienists. The senile insanities are not yet elucidated, and only a portion of the exogenous toxic insanities are objectively diagnosed at autopsy. The psychiatrists still cling to the psychogenic origin of most of the forms of insanity, and their position is undisturbed by any adequate efforts at research. In the United States, with 250,000 insane in 350 asylums maintained at an expense exceeding \$50,000,000 per year, there are no institutions of research for psychiatry, either public or private, where the etiology of the insanities are studied by half a dozen men together. This seems incredible in a country where every great industry has a research laboratory. New York spends \$25,000 per year on the Psychiatric Institute on Ward's Island. Only a small part of the Boston Psychopathic Hospital is devoted to research, yet the most valuable work on the whole continent has come from two or three of the staff of this institution, in spite of their many time-consuming routine duties. Michigan and Illinois are the only other states that pretend to have a psychopathic institute, and the Federal Government, which maintains lavish pathologic research in the Departments of Agriculture and Animal Indus-

try, has nothing doing in the little subterranean laboratory at St. Elizabeth's Hospital. The Department of Public Welfare of Illinois expended more than \$10,000,000 on the wards of the state during the last biennial period and less than \$40,000 on the Psychopathic Institute, where research is supposed to be made into cause, cure and prevention of the defects which make custody necessary.

THE VOTARIES OF PURE SCIENCE—THEIR ARGUMENT

There is a paralyzing quibble in relation to the utility of conscious organized experimental research to solve any definite problem. The disputants are in two uncompromising and hostile groups. On the negative are the academic votaries of so-called "pure" science. They are removed from the affairs of life and pursue in salaried serenity abstruse investigations with undisturbed deliberation. They demand unlimited time for the accumulation of endless minutia of data without hope of any ultimate application. They declare that "invention" is no part of "research." They point to the waste of energy made in the past to solve problems of an axiomatically unsolvable nature. They compare all such pragmatic efforts to the search for the philosopher's stone or the elixir of life. Because some paranoiacs are engaged in "inventions" for which they are utterly unprepared by a knowledge of the resources of science necessary to the solution of the problem, they assume that all inventors are irrational. To be engaged on an obviously practical and useful problem or to accidentally stumble upon a happy solution of a pragmatic import is derogatory to the reputation of a research man among his colleagues.

THE DEVOTEES OF APPLIED SCIENCE—THEIR REBUTTAL

On the other side are the worldly utilitarians, the devotees of "applied science," who are eager to accomplish results hurriedly. They insist that we already know much more than we use. They point to the flagrant examples of knowledge buried for decades and half centuries in negligent and wasteful disuse. They point the finger of contempt at an organized body of scientific men so presbyopic that they cannot see the prophet at home. Surgeon Sidellot wrote to the president of the French Academy in 1870 in such a vein:

"The horrible mortality amongst the wounded in battle calls for the attention of all the friends of humanity and science. The surgeon's art, hesitating and disconcerted, pursues a doctrine whose rules seem to flee before research. Places where there are wounded are recognized by the fetor of suppuration and gangrene." This was in Pasteur's country, and ten years after he had given the clearest indications how the wound diseases could be prevented. For three years before the Franco-Prussian war began Lister had actually demonstrated that possibility in practice in the hospital at Glasgow. Crook produced the efficient air pump long before the thermos bottle was given to the public. With the adequate accumulations of "pure science," which had been neglected for twenty years (while enormous sums were lost in quarantine), a few officers of the American Army solved the problem of yellow fever in a single season, and thus abolished quarantine in the West Indies and opened the tropics to civilization. It is the boast of the devotees of "applied science" that they take the oracular interpretations of the replies Nature makes to the allocutions of the votaries of "pure science" and reduce them to the vernacular of human service, even to the slang of vulgar use. "Pure science," they declare, is monastic myopia, egotistic, haughty and unsocial, while the efforts of research for service has always discovered more and greater things than were looked for.

THE RECONCILIATION, THE DEMOCRACY OF SCIENCE.

The votaries of "pure science," those who know, are quite as wide of the mark as the devotees of the "applied sciences," those who do. There is really no sharp distinction between "pure science" and "applied science." The only purity any science can claim is its purity of interpretation. This interpretation can be demonstrated by pragmatic application alone, by its utilization, which is the essence of applied science. Through the application of pure science to the uses of man, civilization advances.

For example, indigo was one of the early agricultural resources of Africa and India. Its production was carried on with religious empiricism and ceremonial and it was a staple industry of many districts. In the last decade of the nineteenth century the coal tar products were used in the production of a wide range of dyes and in

1902 the displacement of natural indigo was so well along that the agricultural production of indigo collapsed, and thousands of agriculturists starved. There is every reason to believe that the application of scientific information to the production of natural indigo would have saved the ruin of a great agricultural industry, for it has again been revived by introducing scientific methods which raised the percentage of "mud" or crude indigo to a profitable point. The ease with which manufacturing chemistry can utilize the votaries of pure science has placed agricultural competitors who can not do so at a great disadvantage. Why is it that America and England, the two countries noted for scientific discovery, mechanical invention and industrial ingenuity, are so negligent in utilizing the stores of "pure science" in conscious experimental research for public health? We are proud of our Wrights, our Channutes and our Langleys, and a long line of scientists all the way back to our Sillimans, our Danas and our Franklins, but we have not had in a position of influence or power any man of broad historical and scientific horizon who at the same time was cognizant and acutely sensitive to the value of the greatest of our natural resources, the public health.

THE LESSON OF THE WAR.

There is a mutual stimulation which the intimate association of the "theoretical" with the "practical" has fermented during the great war. It can be observed on both sides the frontier, but perhaps more typically in the Central Powers. Explosives were necessary, and the sulphur, fats and nitrites were cut off by the blockade. German chemists, therefore, produced sulphuric acid from gypsum or calcium sulphate. The water powers of Germany were soon producing nitric acid from the air, and ammonia was made by direct combination of hydrogen and nitrogen, while our own Niagara Falls were made to yield 100,000 horsepower to produce 180,000 tons of nitric acid per year during the continuance of the war, and there is one million horsepower left unutilized. At the beginning of the Great War, Great Britain was hopelessly deficient in plants for the production of explosives. In two years' time, by calling into service every chemical technologist and every academic chemist in the Kingdom, she was able to equip herself to produce as much armament and munitions every year, as the Central Powers

were able to do after their forty years of preparation.

The war has demonstrated on a large scale the value of direct conscious research. The censorship of the press has not kept this information from wide diffusion. The politicians who wish to maintain their positions as leaders of men, cannot neglect to recognize the value of research into the means of conserving the greatest of all natural resources, the public health. If democracy is to prevail the last word of the civil administrator must no longer be economic efficiency, but social efficiency—no longer the saving of treasure, but the saving of life—no longer the conservation of soil, coal and oil, but the conservation of health and joy of life.

THE PROBLEM OF THE STATE CHARITIES

The custody of the 250,000 insane crowding our 400 asylums, costs not less than \$50,000,000 per year, and drafts not less than 65,000 citizens from homelife and productive industry. More than one-third the total state budget of the larger states is consumed in pessimistic custody of the handicapped. With the exception of the senile, the syphilitic and the alcoholic, the causes of the insanities are absolutely unknown. Nowhere in the United States, and nowhere in the world, is any determined research now going on where half a dozen scientists are engaged in solving the problems of cause, cure and prevention of these diseases. Is this good political economy and good statesmanship? Horatio M. Pollock recommends to the New York Commission of Lunacy, the propriety of expending \$100,000 a year on research into the cause of one mental disease which alone is costing the state \$10,000,000 a year. This disease is dementia præcox. It recruits 20,000 youths a year into a 16-year long custody, which costs \$3,000 for each recruit before demobilized by death. The 140,000 dementia præcox patients now in custody in the United States will cost the forty-eight state treasuries not less than \$420,000,000. This condition has been going on for fifty years with no adequate efforts at research into cause, cure and prevention. The States of Massachusetts, New York, Pennsylvania, Illinois, Indiana and Ohio are each large enough, rich enough and sufficiently enlightened to establish and maintain each a laboratory or institution of research, as Dr. Pollock recommends, devoted to

the solution of the problem of the insanity of adolescence. Six laboratories conducted on a permanent annual allowance of \$100,000 each, and managed by scientific directors with the humane motive, could accomplish in a few years valuable results in life saving. Research must be secure, permanent, continuous and well supported by an enlightened public and professional sentiment in order to produce results.

One hundred and twenty years ago, Benjamin Thompson established in London the Royal Institution, with the object "of alleviating the condition of the poor. The investigations were designed to save coal, to improve cooking and to better the housing of "the submerged tenth." These objects seemed worth while to Dukes, Princes and Bishops who furnished the funds. But the real results were more marvelous than imagination can picture and more productive than volumes can recount. The first chemist, Humphrey Davy, secured to direct the cooking of soup and vegetables, laid the foundation of the chemical industries of England, and Michael Faraday produced the first dynamo and made electric lighting and the distribution of electric power possible. The whole foundation of the electric industries and services which we now accept so thoughtlessly, was laid bare by Faraday on Christmas day, 1821. The works of Tyndall and Huxley are well known to every physician, but perhaps the more recent work of Dewar on the liquid gasses is not so well appreciated. These names and their life works are associated with the Royal Institution established by an American schoolmaster from Concord, New Hampshire, and his aristocratic associates as a scientific research institution designed to dispense information and invention in the place of eleemosynary relief and thus "to alleviate the condition of the poor." The direct relief to the poor was small, compared with the impetus to civilization which the discoveries of Davy, Faraday, Tyndall, Huxley and Dewar have contributed. The attitude of our present state charities toward the insane is just as fruitless, just as cruel and just as irrational as that of the endowed charities of London in 1799 toward the poor, when they threw bread from the church steeples and coins from a galloping horse, but we have no research designed to diminish the need of these wasteful disbursements.

REHABILITATION AND PUBLIC HEALTH CONSERVATION

It is inspiring to see the enthusiasm with which the rehabilitation of our returned wounded soldiers is undertaken by our educated and cultured American women. It is giving them an interest in life—an inspiration for public service which cannot remain isolated. The education of the mutilated adult soldiers has already aroused a productive study of pedagogy which will be valuable to our twenty million students in school. When six institutes of research are devoted to the discovery of the cause, the cure and the prevention of the insanities of youth, it is not unreasonable to expect the discovery of unsuspected possibilities in intellectual activation. If the causes of mental deterioration are discovered and controlled, it might possibly turn out that normal intellectual, mental and moral development could be accelerated. As the bees are able to produce queens from worker pupa, so perhaps a coming generation may produce geniuses from the discoveries made by researches undertaken to prevent and cure the dementias. Great as the incidental results have been from the work of the Royal Institution in conserving the inanimate natural resources of the world and giving mankind power over Nature for the advancement of civilization when "the alleviation of the condition of the poor" was the only direct and immediate motive; it is quite as likely that researches for the discovery of the causes, the possibilities of cure and prevention of the insanities, will give man that understanding of the conditions of mental and moral activity that will multiply the intellectual possibilities of a coming civilization, and hasten the realization of the hopes and ideals of the religionists, the optimists and the utopians.

THE REALIZATION OF THIS IDEAL

In order to initiate a successful research undertaking of such novelty, the friends of the insane and of efficient state service, should combine in petitioning the legislature for adequate modification of the Civil Administrative Code to make the necessary provisions and secure the necessary appropriation. There are many ends to be met.

1. An appropriation of \$100,000 a year, or more, for expenses.

2. Co-operation of the scientific bodies of the state; the educational institutions; the state

hospitals and their patients, and especially the state university.

3. The provision of a research faculty of the first class, without civil service restrictions.

4. A distribution of the efforts at research upon the conditions of defect, proportionately to the number of patients or wards in custody, suffering such defects or disease.

5. Complete isolation of the research faculty from service work, from custodial care and from business management.

6. The autonomy of the laboratory or institute should be complete under the chief with no civil service restrictions, and no complications from teaching, standardizing or exploitation.

It has seemed very appropriate to place this research institute under the existing Board of Natural Resources and Conservation, in the Department of Registration and Education.

With that end in view, a bill has been prepared to be presented in the House and in the Senate, and the active support of that bill is requested of the friends of the eighteen thousand wards of the state. Write your representative and urge its passage, or forward your petition to the author of this paper, who is the Secretary of the Society for the Promotion of the Study of Dementia Præcox.

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TRACHOMA.*

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The word trachoma is derived from the Greek word *trachus*, meaning rough, exemplifying the appearance of the palpebral conjunctiva. The disease is known also as "granulated lids," granular conjunctivitis, and conjunctivitis granulosa, because of this same roughened or granular condition. Another name is "The Egyptian Disease," because it was thought that its proper home was Egypt, and that it was imported into Europe by the soldiers returning from the Napoleonic campaign in Egypt. This belief has also given rise to the term "military ophthalmia." While it is true that about that time the disease became widely spread in all of the European armies, there is evidence to prove that it has been endemic in Europe since antiquity. Either a more perfect

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knowledge of the disease, or its epidemic form, due to the association of large bodies of men under improper hygienic surroundings, has given rise to the belief that it first appeared in Europe about that time, namely, at the beginning of the nineteenth century. It is an interesting commentary on the improvement in prophylaxis and hygiene since that time to note the rarity of the disease in the armies engaged in the recent war.

With the possible exception of the negro, at least in this country and Cuba, no race and no land is free from trachoma, but certain areas seem to be more infected with it than others. For example, it is very prevalent in Arabia, India, Egypt, German, Russian and Austrian Poland, China and Japan. In the United States, although found everywhere to a greater or less extent, it is especially prevalent among the Indians, in the mountains of Kentucky, and in the great eastern centers of immigrant population. In spite of the rigid inspection at the ports of entry, cases slip in, and new foci of infection are formed due to the tendency of the foreigners to seek their countrymen, amid whom they live under improper hygienic surroundings.

This wide dissemination of the disease is important for two reasons: first, because its destructive effect upon the eyesight is daily adding to the quota of the blind of every nation; and second, because its infectious character makes even a single case a source of danger to the community in which it exists. Reference to these points will again be made, later. It is sufficient to say here that it has been estimated that 9.4 per cent. of all blindness is due to trachoma, more than any other disease except blennorrhea neonatorum, and that this disease can be classed among the preventable causes of blindness.

As the name granular conjunctivitis indicates, it is a disease primarily of the conjunctiva, though its influence in causing blindness is exerted through the complications affecting the cornea. Its pathologic anatomy consists in numerous, local inflammatory infiltrations of the conjunctival adenoid tissue. These enlarge and form the "granulations" which are characteristic of the disease. These may be present as isolated follicles, more or less hidden by the hypertrophied conjunctiva which takes on a papillary character. Or the follicles themselves may be so numerous as to be the predominant feature of the disease. Finally there may be any stage of gradation between

these two forms. These granulations are round collections of lymphoid cells, which may possess an incomplete capsule. Their chief constituents are mononuclear leucocytes, with some phagocytes and multinuclear cells, surrounded by a more or less complete zone of lymphocytes. Beneath the follicles are dilated blood vessels, which sometimes extend into them, while the surrounding tissues are infiltrated with leucocytes. The granulations are eventually crushed out of existence by the contraction of the scar tissue, which arises from the elements of the follicles themselves, or more likely from a proliferation of the conjunctival connective tissue. With the granulations, the conjunctiva proper is destroyed in large part, so that on inspection, especially of the tarsal plate of the upper lid, there is the appearance of numerous small red spots separated from each other by white bands. With the contraction of the scar tissue is associated changes in the position of the eyelashes and of the lid as a whole.

As to the etiology, little can be definitely stated. We know that the disease is highly contagious, but its transference is brought about only by actual contact of the nonaffected eye with some article contaminated by the secretions of the affected eye. Therefore, while not contagious in the same sense as influenza and similar diseases, it is probably caused by some microorganism, the nature of which has not been satisfactorily settled. Several authors have demonstrated in the granulations and the discharge the presence of small granules resembling diplobacteria, the so-called "trachoma bodies," or "Prowazex-Halberstaedter bodies." They occur either isolated or grouped together within the cell, next to the nucleus, and are for that reason sometimes called "inclusion bodies." As they are found in fresh, untreated trachoma, and also, though less frequently, in old, chronic cases, and as they are very rarely found in conditions other than trachoma, it is very probable that they have some etiologic relation to the disease, but that they are the cause of it, and what their nature is, have not been satisfactorily determined.

The symptoms of trachoma vary with the stage of the development. In the beginning, the patient may be very little inconvenienced. He will notice a heavy feeling of the lids; the eyes will feel tired, and there will be a slight amount of secretion, perhaps just enough to cause the lids to stick together in the morning. On examination the

lids may appear slightly swollen externally, but on everting them there will be found a number of greyish-white, semitransparent bodies resembling grains of sago, imbedded in the conjunctiva. These will be found most numerous in the folds of transmission and over the tarsal plates, very rarely on the ocular conjunctiva. The conjunctiva, as a whole, may be only slightly injected, but appears roughened, owing to the presence of the granulations. This stage may last weeks or even months.

On the other hand, the initial stage may be accompanied by more fulminating symptoms. There may be lachrimation, photophobia, pain, considerable discharge, and other symptoms of acute conjunctivitis, together with the formation of hypertrophied conjunctival papillæ, in fact, all the symptoms of the usual second stage of the disease. The lids will be more swollen, and the conjunctiva will be very red, swollen and roughened, the granulations blending with the papillæ to give a cobblestone or raspberry appearance to the inner surface of the lid. During this stage the original follicles undergo degeneration and destruction, while new ones are formed to pass through the same cycle. As these successive crops of follicles appear and disappear, their places are taken by scar tissue, whose contraction heals the original lesions, but going further, ushers in the stage of cicatricial trachoma.

The stage just described may last several months. In it appear for the first time the complications affecting the eyeball. These are corneal ulcers and pannus. The ulcers may be one or several in number, and may be located anywhere on the cornea. The pannus, which is a form of vascular keratitis, is always located primarily in that part of the cornea covered by the upper lid, though it may ultimately cover the entire cornea. It is caused by the development of blood vessels and round cells between the corneal epithelium and Bowman's membrane, hence is superficial. It may, however, be accompanied by softening and ulceration, in which case the substantia propria of the cornea may be invaded and permanent scarring result. There are two theories as to its etiology; one, that it is caused by the rubbing of the roughened conjunctiva upon the surface of the cornea during the movements of the lid, hence is mechanical in origin. The other is that it is a manifestation of the disease itself, as a corneal involvement. Although pannus is

very formidable in appearance at times, it will usually disappear completely under proper treatment, at least from a microscopical standpoint, though it may leave behind an irregular astigmatism.

The ulceration and pannus may be accompanied by irritation of the iris or even a true iritis. When this is present, the subjective symptoms are intensified.

The cicatricial stage is marked by the appearance in the conjunctiva of fine white lines, and these increase in length and width, forming a network, in whose interstices the remnants of conjunctiva appear as red islands. The amount of scar tissue depends on the age of the process, the severity of the disease, and the lack of treatment or its improper character. As this scar tissue contracts, the culdesacs are obliterated, adhesions between the ocular and palpebral conjunctiva develop, and the whole conjunctival sac shrinks, drawing the lids close together, limiting their movements and narrowing the palpebral orifice. While this process is taking place in the conjunctiva, the underlying tarsal plates yield to the constant traction exerted by the contracting scar tissue, and begin to bend upon themselves. Their lower margins, being freer, curve inward towards the eyeball, carrying with them the eyelashes, causing the condition known as trichiasis. Eventually, the margins and lower parts of the lids will be curved inwards against the eyeball, a condition called entropion. The constant rubbing of the cornea by the eyelashes causes subjectively intense pain and objectively abrasion of the corneal epithelium with opacification of the cornea from a traumatic keratitis, or the formation of ulcers. These latter may heal with the formation of opacities of the cornea, or they may perforate with infection of the interior of the eye or with prolapse of the iris and staphyloma formation. On the other hand, a staphyloma may develop as the result of a weakening of the cornea constantly traumatised by the eyelashes, and its yielding to the intraocular pressure. Whether the result of the trichiasis and entropion is corneal opacity or staphyloma, or both, the net result is the same, namely, complete or almost complete loss of sight. It may even be necessary to remove the eyeball to secure relief from the pain. Acute exacerbations are not uncommon, especially if a case which is progressing towards a cure is neglected. When the cornea has once been the

seat of an ulcer, it is very likely to suffer from subsequent ones, either at the site of the original one or elsewhere.

The treatment of trachoma resolves itself into three phases; prophylactic, medicinal and surgical. Of these the first is by far the most important, because with its complete performance the other two will become unnecessary. It cannot be too strongly emphasized that trachoma is a preventable disease. Owing to the fact that its communication is dependant on actual contact with the affected eye or some article contaminated by secretions from it, the prevention and ultimate total eradication of trachoma depends on the ability to isolate the affected individual completely. It may be said that such a procedure is not practicable. Perhaps not, but it is the only one which will completely stamp out the disease. So long as individuals so affected are allowed to mingle with normal individuals, just so long will the disease continue to propagate itself and take its toll of eyesight. Even regulations approximating isolation have a marvelous effect. While I was in practice in St. Louis, it was my fortune to have charge of a clinic to which the school children of the neighborhood were referred by the school physicians and nurses. In the beginning of this medical supervision of the schools, a large number of cases of trachoma and follicular conjunctivitis was discovered. In every case the child was compelled to remain away from school until the danger of infecting other children was thought to be passed. This regulation created much protest on the part of the parents and teachers, and frequently of the children, but it was persisted in, with the loyal cooperation of the school nurses and physicians. The result was that the next year the number of new cases was only about 5 per cent. of the first year, and the following years a case of trachoma from these schools was a rarity. Of course, these children were treated at the clinic meanwhile, and were instructed in home prophylaxis, which was carried out more or less faithfully, and since they were seen in the earlier stages were cured, but the point I wish to emphasize is the almost complete eradication of 3 or 4 foci of infection by the simple regulation of compelling the children to remain away from school. How much more good, then, could be accomplished if complete isolation under treatment were practiced whenever a case presents itself.

But why wait for the case to present itself for treatment? Inasmuch as the early stage sometimes develops so insidiously that the patient either is ignorant of a diseased condition of the eye or neglects it either from carelessness or economic reasons, it frequently happens that by the time he comes for treatment the case is well advanced and opportunities for infecting other people have been numerous, and probably have resulted in initiating other cases. It is clearly evident that if we wish to prevent the spread of trachoma, it must be attacked where there is the greatest likelihood of its obtaining a foothold, or an eyehold if you prefer. Places where large numbers of people are in more or less intimate contact for a long time should be kept under medical inspection repeated at frequent intervals. Especially should this be true of schools, factories, department stores, hotels and all large businesses. I have seen a street car conductor rub his eye, then with the same hand, moistened with saliva, give a transfer to a passenger. If the former had trachoma, it is very possible that the latter subsequently developed it, and wondered where he got it. On the other hand, the conductor may be the innocent recipient of such a gift from some infected passenger. It is but fair to both sides that the only one who can be controlled, namely, the conductor, should have his eyes examined at intervals sufficiently close together to catch the disease in its earliest stage if present. The roller towel, now happily a memory in most hotels, offices, etc., should be completely abolished, not only on account of trachoma, but also on account of other communicable diseases. At home, the patient should use individual towels, etc., to avoid as much as possible contact with other members of the family, and observe scrupulous cleanliness of hands, face and eyes. Trachoma should be made as reportable as blennorrhoea neonatorum, and the law should be much more faithfully obeyed than that concerning blennorrhoea is in most states.

As to the medicinal treatment, the list is as long as is usually the case in those diseases where the specific agent has not been isolated and an antitoxin prepared. Each physician uses the remedy which has proven itself most successful in his hands. One of the best is a 1 per cent. solution of silver nitrate, especially where there is profuse discharge or corneal ulcers. But if this is used for too long a time, it may produce an

argyrosis of the conjunctiva, to which the patient will subsequently bitterly object. The organic salts of silver are used by many, but I have not had very favorable results with them. Personally I have found that the best results are obtained in all stages by the use of the copper sulphate pencil, applied to the upper fold of transmission once a day, so long as any granulations are present. When these are gone, it is replaced by 2 per cent. zinc sulphate, one drop daily. Throughout the disease the eyes must be cleansed frequently, every 1, 2 or 3 hours with a saturated solution of boracic acid. This is best applied not with the eye cup, which frequently irritates the eye, but with pledgets of cotton well moistened, used to remove gently the secretion which collects on the margin of the lids and mats the eyelashes together. By this method, enough of the fluid will enter the conjunctival sac to remove the retained secretion, and the eye is left feeling refreshed. The boracic acid, itself, probably has little influence on the disease, but its use exerts a psychologic effect on the patient. He will use the solution frequently, when he would neglect the use of plain water.

If iritis or ulcers develop, the use of atropin is indicated, together with smoked glasses. The latter are also of benefit where there is much photophobia. When the disease has been checked, but too late to prevent the formation of corneal opacities, an attempt can be made to clear these up by the use of dionin, or of yellow oxid of mercury and massage. When this yields no further results, the astigmatism present can, to a certain extent, be relieved by the use of glasses.

The use of silver nitrate or copper sulphate causes considerable pain which can to a certain extent be prevented by the preliminary use of cocain. However, when the effect of the latter wears off, the pain appears, frequently, with greater intensity. So many of my patients who have been treated with and without the cocain have stated that they prefer the pain at the time of the application, that I have entirely discarded its use except for the first few treatments. The pain can be alleviated to a certain extent by liberal applications of warm or cold water, the latter usually being preferred by the patients.

The above medicinal treatment represents the result of my own experience. I do not claim that equally good results cannot be obtained by other drugs which have been recommended, but I have

not found them equally efficacious. The time limits of this paper will not permit their description.

Since the surgical treatment will be taken up in the discussion, I will give merely a brief survey of it here. In the beginning of the disease, some form of expression of the granulations is to be employed, followed by the usual medicinal treatment. In the cicatricial stage, the surgical treatment is to be directed against the maleficent effect of the trichiasis and entropion. Sometimes a simple canthoplasty is sufficient, but usually it is necessary either to move the lashes further away from the lid margin, or to create a new lid margin, or even to remove the tarsus. An optical iridectomy may be of service in case of corneal opacities.

In conclusion, I would emphasize the following points:

Trachoma is a widespread disease, easily preventable, and readily cured if seen early enough, but neglected, leading almost inevitably to blindness of a greater or less degree, accompanied by pain and ocular deformity. It could be stamped out if all new cases were promptly isolated, and its spread can be checked by even less drastic methods of prevention. Large groups of people constantly associating should be subjected to regular medical supervision, so that a case may be early recognized and the spread of the disease avoided. Finally, every case of eye disease presenting a discharge, however scant, should be examined, as the early symptoms are no criterion of the severity of the disease or its progress.

SOME PRACTICAL POINTS ON THE TREATMENT OF DIPHTHERIA, SCAR- LET FEVER AND CEREBROSPINAL MENINGITIS.*

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Your knowledge of diphtheria is so complete that it is with a feeling of extreme delicacy that any suggestions pertaining to this disease are made. Nevertheless, we note that day by day patients suffering from this ailment are lost in spite of the incontrovertible fact that there is always

*Read before the Englewood Branch, Chicago Medical Society,
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available an absolutely definite specific remedy. And why then so many diphtheria deaths? We have health departments in our cities constantly striving to combat such losses. We have laboratories with free culture outfits and free examinations made as an aid to the physician and a benefit to the patient.

It may be true that the thought of eliminating diphtheria as a cause of death is too idealistic. Nevertheless, much can be done toward this end.¹ But aside from the fact that many parents do not summon medical aid sufficiently early to have their children spared an unnecessary death, it is equally true that many physicians delay too long in administering the proper treatment.

One point to be emphasized naturally in diphtheria as in any other disease is the matter of diagnosis. This, of course, is the first step toward recovery. But the great error so often made is to delay diagnosis based on clinical findings for a laboratory diagnosis by means of a culture. Practically at least this is the wrong method of procedure. In order to reduce mortality the diagnosis must be made on clinical signs, antitoxin administered at once, and then every effort made to confirm the diagnosis by laboratory examinations—the examinations of cultures; for it is not infrequent to find in a large contagious disease hospital patients with frank clinical diphtheria from whom several negative cultures may be obtained before a positive one is eventually secured. Under such circumstances in private practice if the physician delays making his diagnosis and fails to give antitoxin until a positive culture is reported by the laboratory, not only is much valuable time lost, but the patient may ultimately be lost as well.

In general, the best method for administering antitoxin is intramuscularly, and it seems to me the outer muscles of the thigh offer the most suitable site for injection, although the gluteal muscles are very often chosen. Park² has shown that by the intramuscular route the absorption is about twice as rapid as by the subcutaneous. Consequently the beneficial effects are much more quickly seen. Also there appears to be less discomfort. The intravenous method should be the one par excellence and always resorted to in desperate cases. Nevertheless, severe shock is sometimes produced and death has occurred in cases with a persistent thymus. It is always well to desensitize patients according to Besredka's

method when antitoxin is given intravenously, and it is needless to say the antitoxin should be warmed (98°) and injected very slowly.

Many forms of treatment have been devised for diphtheria carriers, and most of them have been successful some of the time, but none of them most of the time. Tonsillectomy is, however, by far the superior of all other methods for dealing with chronic carriers.

Before leaving the subject diphtheria, at least a word should be said in regard to prophylaxis. All practitioners are naturally familiar with the fact that a child recently exposed to diphtheria may be protected by an immunizing dose of diphtheria antitoxin (passive immunity). But extremely few general practitioners appear to possess any knowledge whatsoever in regard to the method of active immunity.

Toxin-antitoxin (T. A.) or diphtheria prophylactic as it is sometimes termed, is put up in one c.c. sterile ampoules. Each ampoule contains approximately one unit of diphtheria antitoxin and the amount of diphtheria toxin which this one unit will neutralize. A prophylactic treatment consists of three ampoules injected subcutaneously at intervals of one week—three ampoules in all being used. At present the dose is the same for all ages.

Theoretically, T. A. would only be given to those individuals who had positive Shicks, but in infants and young children it is better to disregard the Shick. Moreover, it should be borne in mind that T. A. is not to be used as a substitute for diphtheria antitoxin where immediate protection is sought for the individual. It usually requires from one to four months to establish an active immunity. But the duration of this immunity may be anywhere from 18 months to life.

Reactions in infants and young children are seldom, if ever, seen, but in adults both local and general reactions may be severe.

Scarlet Fever: Perhaps the first thing of importance regarding this disease which should be impressed on the general practitioner is the necessity for taking cultures from both nose and throat in every case. Do not regard the discharges from nose or throat as merely a part of the disease. Be unwilling to believe that a membrane on the tonsil is a "scarlet fever membrane." And if you are in doubt, give antitoxin anyway.

Diphtheria is one of the commonest complications of scarlet fever in Chicago, even though we

find such authorities as Nothnagel³ attributing many of the diphtheritic throats in this disease entirely to the scarlatinal toxin.

In the year 1914 of 685 scarlet fever patients received at the Cook County Hospital, 199 were admitted with a complicating diphtheria. And in 1917, at the same institution, of 816 cases, 115 also had diphtheria on admission. It is my firm conviction that during an epidemic there are many scarlet fever patients treated outside the hospitals who die as the result of a complicating diphtheria without this latter fact ever being ascertained by the attending physician.

Another point of extreme importance in the management of scarlet fever is the choosing of a proper diet. We are all familiar with the old teaching in this respect, and we even find Osler⁴ saying, "It is better if possible to confine the patient to a strictly milk diet." Others tell us confinement to bed for at least three weeks "in order to make a successful endeavor to avoid nephritis," is necessary, for nephritis is customarily looked upon as the pre-eminent complication of scarlet fever. In this connection we read in Nothnagel that "patients must not be allowed to leave their beds before the process (desquamation) is complete." As 5 or 6 weeks are often required for desquamation, this would mean that period spent in bed. Practically in the observation of some five or six thousand scarlet fever patients we find no such measure is necessary. Such forms of treatment were the routine practice in the contagious disease department of the Cook County Hospital until the close of the year 1914. Through the courtesy of Miss Mary Watson, the efficient superintendent of nurses in the contagious disease department of the Cook County Hospital, it is possible to present some accurate comparisons in the different modes of treatment.

In the year 1914 out of 685 cases of scarlet fever there were 42 patients who developed nephritis. This refers to true nephritic cases and, of course, does not include those patients who merely showed a trace of albumin and hyaline casts early in the disease, for the latter is more the rule than the exception in many diseases accompanied by fever.

About 1915 an effort was made to change the system of feeding the scarlet fever patients at the County Hospital. Instead of a diet consisting principally of milk, fruit juices, orange, prune, etc., and vegetables were substituted. In other

words, milk was given a minor place in the diet instead of occupying the chief role. As soon as the temperature was normal or approximately normal, usually within three or four days, a full soft diet was inaugurated, unless there was some special contraindication to so doing; that is, the patient was allowed practically everything except meat, and the giving of fruit juices was continued. The object of the new diet was to avoid an acidosis, which favors an inflammation of the kidneys. An exclusive milk diet may most certainly produce an acidosis with a subsequent nephritis.

Now note the results which may be attributed to the change in diet. It was previously mentioned that in 1914 out of 685 scarlet fever patients there were 42 cases of nephritis. In 1917 out of 816 patients there were but 14 cases of nephritis. In other words, nephritis, as a complication of scarlet fever, was reduced from approximately 6 per cent. in 1914 to about 1.5 per cent. in 1917. And it should be further stated that most of the 1917 patients developing a nephritis were children who had been treated at home for one or more weeks before entering the hospital. The bearing which the last statement has on the matter is simply this: Presumably patients treated at home for some time before admission to the hospital were on either an exclusive milk diet or a chiefly milk diet, which enhanced the likelihood of a post-scarlatinal nephritis.

Another matter pertaining to the subject of nephritis is the question as to how long a patient should be kept in bed. To set any definite time arbitrarily as three weeks or four weeks or less is not reasonable. The average case of scarlet fever which has been on a fruit juice and vegetable diet from the beginning may be allowed out of bed in a week or ten days, provided there is no special contraindication, without any danger whatsoever. The one advantage of keeping patients in bed in a contagious disease hospital is diminishing the possibilities of crossed infections.

The ears are another very constant source of concern in scarlet fever, and we find in dealing with them, as with other conditions, that it is just as important to know what not to do as it is to know what should be done.

Previous to the year 1915 the routine practice at the County Hospital was to irrigate all discharging noses, throats and ears. It was believed that irrigation was the only satisfactory method of caring for the cases with profuse oral and nasal

discharges. In 1914 there were 69 cases of otitis media and 10 mastoids among the scarlet fever patients. About the year 1915 all irrigations of nose, throat or ears were ordered stopped on my patients, and it was not long before this policy was applied to all patients in the contagious disease department of the Cook County Hospital. Again note the result: In 1917 out of 816 scarlet fever patients there were but 22 cases of otitis media and only one mastoid in the entire year, if we exclude one other mastoid case which was sent into the hospital for operation. There was consequently a reduction from 10 per cent. for otitis media as a complication in 1914 to 2.5 per cent. mastoid a month in 1914, we had but one mastoid in 1917. And, whereas, we averaged nearly one develop in the entire year of 1917.

It seems like a matter of very plain reasoning to see that nose and throat irrigations frequently force infective material up the eustachian tubes and thus cause aural complications. Based on a similar hypothesis, it is also evident that even when no irrigations are used the tendency to otitis media will be greater if the patient lies flat in bed than if the head is well elevated on a pillow; for then, as a simple matter of gravity, secretions may be expected to run down and not up the Eustachian tubes to the ears.

While there is no specific drug in the medication of scarlet fever, there is at least one form of treatment which often gives truly marvelous results. This is the use of convalescent human serum. The donor of such serum, however, must at least have had a Wassermann first made before he is accepted. Suitable serum may then be given intravenously in quantities of from 30 to 60 c.c., and repeated as required. It is the severe toxic cases in which the results are so striking. In mild cases the use of convalescent human serum would hardly be necessary. While the preparation and treatment with human convalescent serum would ordinarily have to be done in a hospital, still the same principle of treatment could be carried out in a home where a donor is present. Under such circumstances the whole blood of the donor can be used, injecting it into the patient subcutaneously. Splendid results have been accomplished in this manner.

Desquamation in scarlet fever probably plays no part in the dissemination of the disease. However, if a patient is permitted to leave a hospital with discharging ear, nose or gland, there is al-

most certain to be a return case, if there are other children in the family. The author knows of one instance where there was a return case following the discharge of a patient who was in the hospital for 113 days. This child was being held because of an otitis media which had not entirely ceased discharging. She was released only when the family obtained a permit to take her from the hospital.

There are other instances of return cases where the outgoing patient is not the source of infection. When a return case (a second case of the disease in the family following the homecoming of the original patient) occurs, it is customary for the patient's family to accuse the hospital of carelessness in dismissing the patient. The usual charge is that the hospital was negligent in the disinfection of the child's body or clothing or possibly that a desquamating patch of skin was discovered on one of the heels of the patient after she came home. There is, however, another version for this, and it is frequently the correct one, when the patient released from the hospital is one who has passed through an uncomplicated attack without suppurating ears or other discharges.

The whole fault in many of the return cases does not lie with the hospital at all. The entire trouble is due to faulty methods of disinfection at the time the original patient was sent to the hospital. Very often clothing and toys which belonged to and had been handled by the first case are put away without disinfection or following incomplete disinfection, when the original case is removed to the hospital.

All these articles, clothing and toys, may be secluded in a closet until the happy return of the recovered child. Soon, however, clothing is gotten out, and the old playthings in retirement for several weeks are again brought forth for the amusement of the convalescent and his brother or sister. It is but a short time before another member of the family has acquired the disease. That many secondary cases are acquired in such a manner is, in my opinion, an absolute certainty.

Those of you who are not familiar with the activities of the Municipal Contagious Disease Hospital, an institution by the way in which the entire city should take pride, may be interested in a few brief statistics for the past month (December, 1918): In 156 cases of straight diphtheria (excluding laryngeal) mortality 7 per cent, which is very low for hospital cases. In 23 laryngeal

cases, mortality 21.3 per cent., which is below the average for this type. Among 21 straight scarlet fever patients there were no deaths, while in 12 cases of scarlet and diphtheria the mortality was 16.6 per cent. The mortality for all scarlet fever patients was 6 per cent.

Cerebrospinal Meningitis: This disease has been referred to as one which shows a special predilection for infants and soldiers, or, we might say, for infants and infantry.

During the past year we have heard of the extremely high mortality rates for epidemic meningitis in some of the army cantonments where there is every opportunity for early diagnosis and treatment of the patients. Consequently, it should not be surprising to learn that the mortality rate for this disease at the Cook County Hospital, where the patients are usually received late, has ranged at various times in recent years from 30 to 70 per cent.

Quite frequently physicians who are ordinarily well informed will inquire if the anti-meningococcic serum is really of much value. Under proper conditions, I should say that it is of just about as much value for this disease as diphtheria antitoxin is for diphtheria.

The most favorable results are to be expected, however, when an early diagnosis is made and the serum promptly used.

A lumbar puncture is necessary for accurate diagnosis and is imperative for proper treatment. The spinal fluid will be found under increased pressure and turbid. Often it is lemon tinted in color, and 40 c.c. to 60 c.c. may often be withdrawn on first puncture. In some cases, however, the fluid is so thick with pus that the spine is drained with difficulty. On examination the intracellular organism may be expected to be found and a cell count of many thousand per cm. is the rule, with the polymorphonuclears overwhelmingly predominating.

When giving serum intraspinally, the gravity method is followed, no syringe used. And no effort should be made to replace the spinal fluid withdrawn with an equal volume of serum. It is far better, when possible, to withdraw twice as much spinal fluid as you intend to give serum. By this plan the pressure in the spinal canal will be lessened and improvement usually will be more readily noted.

Spinal punctures should be made daily for at least three days in succession, and serum given in

amounts depending upon the quantity of fluid withdrawn. After this period the symptoms will determine the frequency with which further punctures are to be done. As long as the spinal fluid is turbid, it is well to withdraw as much fluid as possible with each puncture made. After the first three or four days' treatment, however, intraspinal serum is not necessarily demanded when a puncture is made.

Although the use of anti-meningococcic serum intravenously has received little attention in Chicago until the past year, still this method is by no means new. In fact, it is my impression that the intravenous route was employed in this disease by Besredka and others many years ago.

If the intravenous route, as well as the spinal, is used, as it most certainly always should be in adults, many cases will be saved which would otherwise terminate fatally. However, before administering, the serum should first be warmed to 98° Fahrenheit. Intravenously a syringe must be used for introducing the serum into one of the veins of the forearm. The injection should be made slowly.

An intravenous injection of serum may be given immediately after the introduction of serum intraspinally. Amounts of 30 c.c., 40 c.c., 60 c.c. or more, may be given at a single dose into the vein, depending upon the seriousness of the case.

If some marked improvement is not shown in the patient's condition by the end of the three or four days' treatment, a different make of serum (the product of some other firm) should be chosen, as it may be that the first serum used has not been prepared from the proper strain of organism to meet the requirements of this particular case.

It is often very striking to observe the remarkable improvement in a patient who has not responded to one manufacturer's serum after a change of serum is made.

While there may be no limit to the amount of serum which can be given intravenously, there surely is a point beyond which it is not wise to go with the intraspinal method: for by repeated injections of serum intraspinally an aseptic meningitis may be produced after the original symptoms have subsided, and we produce and cause to continue in evidence all the clinical symptoms of the disease, as marked rigidity of neck, mental disturbances, etc.

In severe cases where the spinal fluid is often

thick and comes only in drops, it is well to elevate the head of the bed about 4 feet for 4 to 6 hours previous to puncture, and following the giving of intraspinal serum, it is often advisable to elevate the foot of the bed for about 6 hours in order to facilitate the flow of serum up to the meninges of the brain.

In young infants, when a dry spinal tap is encountered, it is necessary to tap the ventricles and introduce serum in this manner. Forty c.c. to 50 c.c. of fluid may generally be obtained in this way by the first puncture, and lesser amounts afterward, as a rule.

As a final word on this subject, it must not be forgotten that intravenous medication in infants or young children is not a simple matter without dissecting down on the vein. However, in these classes of patients the intraspinal administration of serum usually gives good results when employed early in the disease.

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TONSILLAR HEMORRHAGE.*

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The frequency with which tonsils are operated upon and the fact that tonsillar hemorrhage is the most frequent and urgent complication, makes the subject worthy of serious consideration. Fortunately tonsillar hemorrhage is rarely serious and still more rarely fatal. However, it is of great importance that the least possible amount of blood be lost by the patient. This is especially true in children and in the emaciated. A serious hemorrhage or a mild continuous bleeding, if it does not result fatally, prolongs the convalescence unnecessarily on account of the resulting secondary anemia.

The fortunately rare complications of lung abscess and pneumonia following tonsillectomy are caused by the inhalation of blood and infectious matter from the tonsil during general anesthesia

and can be minimized by careful attention to hemostasis.

The statistical frequency of tonsillar hemorrhage is unreliable because unfortunately most of the cases are not reported. Richards in 1909 collected opinions of 77 operators on the question of tonsillar hemorrhage and found there was great variation of opinion, from none at all up to 10 per cent. of the cases. Out of 1,000 tonsillectomies done since 1911 at Johns Hopkins Hospital, bleeding occurred in 38 cases after the patient was sent back to the ward after the operation, in 12 of which it was severe and in 26 slight. The division of hemorrhage into arterial, venous and capillary types is of not much practical value, but it is of much more importance to recognize that the bleeding is from one or more points. It is also of academic rather than of practical interest to enter into the details regarding the blood supply of the tonsil, which is numerous and profuse on account of all of the important vessels in its locality supplying it with branches, but it is of more practical importance to be familiar with the sites of prediction of tonsillar hemorrhage, which in order of frequency are: 1. In the upper third of the tonsillar fossa, i. e., the supratonsillar fossa, from the descending palatine branch of the ascending pharyngeal artery. This bleeder is often concealed under the angle formed by the junction of the anterior and posterior pillars.

2. In the middle third of the tonsillar fossa, from the tonsillar branch of the facial artery.

3. In the lower third of the tonsillar fossa, from the dorsalis lingual artery and a venous plexus.

From this it is readily recognized that the source of tonsillar hemorrhage is in the tonsillar bed, which is the triangular fossa left after complete enucleation of the faucial tonsil and that in point of frequency bleeding most often comes from its upper one-third, then in the middle one-third and lastly in the lower one-third. Seventy-five per cent. of tonsillar hemorrhage comes from the anterior one-third of the tonsillar fossa.

Classification of tonsillar hemorrhage:

I. *Primary Hemorrhage.* Nearly always present in every tonsil operation and is, therefore, the most frequent form of bleeding. It may occur during or immediately after the enucleation of the tonsil. It may cease spontaneously or may be

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controlled by the pressure of a gauze sponge on a hemostat if it is a capillary oozing and if it is an artery or a vein it is best controlled by the application of a catgut ligature.

II. *Secondary Hemorrhage.* 1. Early secondary or reactionary hemorrhage usually appears from one to four hours after operation, but it may occur any time within 24-36 hours after the operation. Many of these cases are continuous primary bleedings which have been overlooked at the time of operation. The most serious cases of hemorrhage belong to this group. Early secondary hemorrhage occurs in from 1 to 5 per cent. of all cases.

2. *Late, delayed or true secondary hemorrhage* occurs from the 4th to the 7th day, at the time of the separation of the sloughs. It is very rare. Hemorrhage has occurred as late as 12 days after operation.

3. *Recurrent secondary hemorrhage.* One or more distinct hemorrhages occurring during week following the operation. It is very rare. Regarding the late appearance of tonsillar hemorrhage, I wish to relate a recent personal experience. A girl, 12 years of age, who six months previous had an attack of acute rheumatic fever associated with acute endocarditis and a mitral regurgitation, but otherwise was in good physical condition at the time of operation. Bilateral tonsillectomy was done by the Sluder method, both tonsils being completely removed with the capsule.

No troublesome bleeding was experienced at the time of operation. All bleeding was entirely controlled by gauze sponges. No hemostats or sutures were needed. The patient was able to leave the hospital the next day and continued to make an uneventful recovery until the ninth day, when after dinner and while at play a hemorrhage occurred, which was so intractable that the physician called recommended her removal to the hospital that night. The next morning I examined her and found her nearly exsanguinated, but with the bleeding stopped. In the left tonsillar fossa in its middle third was a small clot, a little larger than a pin head, which covered the site of the previously bleeding vessel. The hemorrhage apparently had been caused by an erosion of one of the small tonsillar vessels. Both tonsillar fossæ were completely healed and free from slough. An examination of her throat several months after showed a very minute linear scar at the site of hemorrhage.

CAUSES OF TONSILLAR HEMORRHAGE.

I. *Predisposing causes:* 1. Hemorrhage occurs more often in adults than in children, due to increased fibrosis and larger blood vessels, and, therefore, greater blood supply.

2. Hemorrhage occurs more often in males probably on account of greater blood supply, and to the presence of high blood pressure diseases and also true hemophilia only occurs in the males, but this disease is rare.

3. General diseases predispose to hemorrhage either by causing a deficiency in fibrin as hemophilia purpura, anemia, a leukæmia and hyperthyroidism or to high blood pressure caused by cardio-vascular-renal disease.

4. Local conditions: Abnormalities in size or distribution of the blood supply of the tonsils. All acute inflammations of the tonsils and benign or malignant tumors of the tonsil, increase the size and vascularity of the tonsil; fibroid tonsils in which the vessels are unable to contract on account of being embedded in fibrous tissue and the adherent and submerged tonsils in which there have been numerous attacks of tonsillitis or peritonsillitis causing cicatricial adhesions of the tonsils and its capsule to the pillars and tonsillar fossa and likewise tonsils which have been previously operated upon and not successfully removed in which there is scar tissue present.

II. *Exciting Causes:* 1. Operative traumatism. The amount of hemorrhage varies somewhat with the technic of the operation. The Sluder method with the tonsillotome causes more bleeding than the Sluder method with the snare or the so-called Beck's method. The dissection method with the knife or scissors is generally regarded as more apt to give rise to bleeding. There is less primary bleeding usually under local anesthesia on account of the vasoconstrictor action of cocaine and adrenalin, but after this effect has worn off a vasodilation occurs, during which a reactionary hemorrhage may appear. The skill of the operator is of more importance than the method of operation used. Any method with which the operator is familiar and proficient is the best and most efficient method for the operator.

Faulty technic and clumsy manipulation cause injury to the muscles forming the tonsillar fossa and always result in hemorrhage. Imperfect hemostasis is a frequent cause of early secondary

hemorrhage which in reality is a prolongation of the primary bleeding at the operation and should have been avoided by previously having attained perfect hemostasis before the patient is removed from the operating room.

Sudden and strenuous physical exertion, straining, retching, vomiting, hawking, coughing, sneezing, too forcible gargling, and the eating of coarse and irritating foods too soon after operation have all been indicted as the exciting causal factor in tonsil hemorrhage.

TREATMENT OF TONSILLAR HEMORRHAGE.

1. *Prophylactic.* The occurrence of an alarming hemorrhage may be avoided by the proper selection of cases and by taking special precautions in cases where the operation is a therapeutic necessity, but the case is not suitable and in some cases avoiding all operative interference. The causes of tonsillar hemorrhage should always be borne in mind and avoided when possible. One of the golden rules of tonsillar surgery should be "Never do a tonsillectomy until 3 weeks after an attack of acute tonsillitis."

Regarding the hereditary hemophiliacs and the other bleeders, operation is only indicated when the necessity is urgent and then only after special treatment has been instituted to increase the coagulability of the blood. A blood coagulation time test should be made on every case suspected of being a bleeder and a prophylactic injection of horse-serum should be given if the coagulation time exceeds seven minutes. In serum therapy we have the most efficient hemostatics, which seem to stimulate blood clotting by supplying the deficiency of fibrin ferment. Instead of horse serum, fresh human blood serum or whole human blood may be used. The internal administration of calcium salts is considered of doubtful utility clinically by many, although Wright claims that coagulation of the blood is accelerated with one or two 15-grain doses of calcium lactate reaching its height in 24 hours and lasting until the third day. The increase of calcium ions in the blood beyond the physiological point inhibits coagulation. The cases of diminished coagulability of the blood due to deficiency of calcium have been proven to be rare.

2. *Treatment of Primary Hemorrhage.* The operation should be performed under efficient anesthesia, local or general, as best suits the case. As in general surgery, ether is the best and safest general anesthetic in tonsil surgery. It is best

given to the point where the pharyngeal reflex is completely abolished, but never to the point where the patient shows cyanosis, as the addition of CO_2 and the withdrawal of O lessens the tendency to clotting. Blood clotting is stimulated by ether anesthesia, but so also is the blood pressure raised. Good illumination is very essential for good work. After the tonsil is removed make pressure with gauze tampon on forceps in tonsillar fossa. Sometimes the bleeding stops spontaneously even without applying a tampon. The tonsillar fossa should be thoroughly inspected, by retracting the supratonsillar fossa and anterior pillars with retractors. Bleeding may be from the posterior aspect of the anterior pillar which is not apparent until the anterior pillar is retracted and inspected. If bleeding is profuse and cannot be localized insert a sufficient number of small gauze tampons into the tonsillar fossa to control the bleeding, after which release one at a time, starting from below, applying hemostats as bleeding points are exposed. These can now be ligated with catgut. The tying of a ligature is most difficult in the lower one-third of the tonsillar fossa, especially near the base of the tongue. The ligature always gives one a sense of security not obtained any other way because we know that if the bleeding point is ligated the bleeding from that source is absolutely under control. I cannot speak too highly of the ligature method in controlling persistently active tonsillar bleeding. It is singular that the ordinary methods of controlling hemorrhage, i. e., forceps pressure, torsion and ligature commonly used in general surgery had not been made use of in tonsil surgery, until within the last decade. To Cohen of Baltimore we are indebted for bringing to our attention, that the use of the ligature is just as necessary in tonsil operations as it is in general surgery. No doubt the reason that the ligature method was not in use, was because of its technical difficulties encountered in the throat. Cohen devised a simple technic by which the bleeding point caught by a hemostat could be readily ligatured, and Boettcher has devised an ingenious but simple mechanical tyer which makes the art of ligating in the throat less difficult than that done with the unaided finger and with which after a little practice one can readily master the technic of tying a ligature in the throat. The simple ligature is to be preferred to the suture ligature because it is more efficient and less difficult technically.

The temporary suturing of the faucial pillars with or without the gauze pack is unsurgical besides being uncomfortable to the patient and should never be used. The tonsil hemostat clamp is not needed and should never be used to stop a primary hemorrhage as better surgical methods are always available. The use of styptics, such as Monsell's solution, should be prohibited, as they are unreliable and may even be actually harmful, causing a secondary hemorrhage, due to sloughing. All bleeding in both tonsillar fossæ should have been controlled and the tonsillar fossæ dry before the patient is removed from the operating room.

III. *Treatment of Secondary Hemorrhage.*

The reactionary hemorrhages generally start a few hours after the patient has been removed from the operating room, but most of these are continuous primary bleedings which have escaped notice, owing to the patient lying on the back and the blood being swallowed. After the operation the patient should be in the semi-prone position with the head supported and the mouth low or the patient may assume the upright position with the head forward. Many hemorrhages occur owing to lack of attention to post-operative care. The nurse should be instructed to watch the movements of the larynx to see that the patient is not swallowing blood. The use of ice water or small pieces of ice in the mouth, together with an ice bag around the neck, may be sufficient to control light bleeding. Cold causes a reflex contraction of the muscular coat of the small vessels, although experimentally it inhibits blood clotting. The patient should be kept in bed for 24 hours after the operation, the mouth and teeth should be kept clean, a mouth wash is preferable to a gargle; all hot, irritating and coarse food should be avoided. The appearance of blood in some patients will cause an intense nervous excitement and restlessness, often associated with paroxysms of coughing and vomiting, which is best controlled by morphin. The surgical control of the hemorrhage under good illumination consists of the use of the gauze tampon for a few minutes and if this is not successful, find the bleeding point and snap on an artery forceps for a few minutes. These procedures are conveniently carried out at the patient's bedside and if not successful, the patient should be removed to the operating room, put to sleep with a general anesthetic and the bleeding vessel ligated with catgut. Hemorrhage may be due to incomplete removal of the tonsil. A piece of ton-

sil may be left in the supra-tonsillar fossa or at the base of the tonsillar fossa, the removal of which will result in the cessation of hemorrhage immediately. The same is true of a large blood clot which may entirely fill up the tonsillar fossa, which favors bleeding by preventing the contraction and retraction of the open mouths of the blood vessels. The tonsil clamp should only be used when it is impossible to use other methods of controlling hemorrhage and then only temporarily as prolonged use may result in pressure necrosis and sloughing of tissues. In conclusion, I wish to emphasize the importance of careful hemostasis at the time of operation, and to urge the more frequent and general use of the ligature method for the control of tonsillar hemorrhage.

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ABDOMINAL PAIN.

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I wish to call your attention, by recitation of clinical cases, to a few common causes of abdominal pain which are incorrectly diagnosed.

First: Infections of the Fallopian Tubes.

Case 1. Miss A., age 22 years; white; single; Ordinary diseases of childhood with good recoveries. No other serious illnesses. Menses regular, flow moderate and painless for six days.

Present illness: Ten days before entering the hospital patient had a severe pain in right side with much tenderness, some nausea, but no vomiting. Temperature ranged from 101 to 102. The attending physician diagnosed appendicitis and placed patient in bed. After seven days in bed, pain, tenderness and nausea disappeared and patient felt fine.

Patient now comes to the hospital for an interval operation. Physical examination: Leucocyte count 8,000, blood pressure 115 systolic and 80 diastolic. Heart, lungs, chest and abdomen negative. No particular tenderness elicited on examination of abdomen. Vaginal examination negative.

At operation a normal appendix was found. Left tube was inflamed and adhered to uterus and a loop of small intestine. Left ovary looked normal. Adhesions were severed and denuded surface covered.

Tube and ovary left. Right ovary and tube looked normal and had no adhesions and were left in place. Wound closed without drainage. The first five days of recovery were rather stormy, temperature ranging from 100 to 103 rectal. After this, temperature quickly went to normal and remained, but the patient was kept in the hospital nineteen days to prevent a re-occurrence. After being home and about the house for about ten days patient was taken with a pain in right ovarian region, temperature 101.5, and was put to bed by the attending physician. Pain and fever disappeared, but after being up a few days another exacerbation occurred and patient returned to the hospital and after three weeks in bed the right ovary and tube were removed. Right ovary was size of a small orange and filled with pus. Fimbriated end of right tube adhered to ovary. Left tube and ovary seemed normal and were left in place.

In this case the tubal infection might have been diagnosed in the beginning and possibly saved the patient from any operation. At the first operation it might have been possible to realize the necessity of removing the right tube and ovary, thus saving the patient from a second operation.

Case 2. Miss B., age 23 years; single; unemployed. Entered with the following history:

Two and one-half years ago she had an appendectomy for pain in pelvic region, with good results, remaining in the hospital fourteen days. For the past six months she had had severe attacks of pain every few days, pain lasting from fifteen minutes to one-half hour. Local vaginal treatments were thought to produce some relief. Seventy-six hours prior to entering the hospital, patient was seized with a sudden severe pain while defecating. This pain was soon followed by vomiting without relief. Two doctors were in attendance and a hypodermic of morphin gave some relief. The pain soon returned and a third doctor recommended immediate operation.

Physical examination of the patient at the time of entering the hospital:

Heart and lungs normal; abdomen greatly distended and tympanitic, but not tender. Pulse 124, temperature 102.

At operation an intestinal obstruction was found which was caused by a band of adhesions extending from the end of the right tube and ovary to the small gut. A loop of small gut had slipped under this band and was strangulated.

The history in this case should have made the diagnosis complete enough to have warranted the operation seventy-six hours earlier than it was done.

Case 3. Mrs. R., age 24 years; white; married two years; housewife. Family history negative. Three months after marriage had an artificial abortion on a two months pregnancy. This was followed

by considerable local peritonitis on left side of lower abdomen.

Present illness: January 21, 1918, had severe abdominal pain which passed over in an hour after the application of hot poultices. January 26, 1918, another severe attack of pain which has persisted for the last 24 hours. No vomiting and patient does not look very ill.

Physical examination: Nearly a normal patient with the exception of a peritonitis, especially marked in lower left quadrant of abdomen. Great tenderness and marked tympanites. Vaginal examination revealed a tender mass in lower left side of pelvis. Rectal temperature 100.4, pulse 98, leucocyte count 23,000. No vomiting.

Operation revealed a band of adhesions extending from the left tube to the small gut about 32 inches proximate to ileocecal valve. Under this band had slipped about sixteen inches of small gut.

Here again the history made the diagnosis very plain.

Second: Gall Stones.

Mr. R., age 29 years; white; married; salesman. Entered the hospital for relief from a ventral hernia. He gave the following history:

For the past three years he had had what he termed "spells of severe pain," with and without vomiting, and when it did occur, seldom gave pain relief. The onset was sudden and pain so severe that the attending physician gave an opiate and put him to bed. These spells occurred with and without fever. They required patient to remain in bed. These spells were several months apart in the beginning but gradually became quite frequent, almost every week.

A diagnosis of appendicitis was made by the attending physician and an operation performed at one of the Chicago hospitals, with relief of the spells for three months. Then they returned with renewed vigor. Another physician was called in and after attending patient through several of these "spells," made a diagnosis of a partial strangulation of bowel, through a ventral hernia which followed the previous operation. Another physician was called and diagnosed ulcer of the stomach, and gave appropriate treatment with temporary relief of pain.

Physical examination showed patient rather emaciated and weak, but complexion clear. Throat clear, heart, lungs and chest normal. Some tenderness over region of G. B. and pylorus, also around hernial opening.

Examination by a competent radiographer was negative. Leucocyte count normal; urine negative; blood pressure normal.

Operation revealed G. B. packed with stones and simple ventral hernia.

The history character of the pain, sudden onset, should have made the diagnosis clear.

Third: Perforating Ulcer of Duodenum near Pylorus.

Mr. S., age 31 years; married; photo-engraver; white. Admitted September 14, 1909. Diseases of childhood, measles, recovery good. Family history negative.

Present history: Weight 130 pounds. Patient says that for several years he has had attacks of dull pain and discomfort in stomach. These attacks came at varying intervals and had no relation to the time of taking food nor to the kind of food he ate. Says that if he starved himself for a few days or only took hot liquid he got well of the attack. Vomited a few times, but never any blood and never any blood in feces. Says there never was any tenderness, but for the past month stomach has been giving him more trouble than at any time previous and was sometimes relieved by taking a little milk. Present attack began about 11 a. m. while at work. Had sudden attack of severe pain in abdomen. Says pain was general, sometimes being in testicles and then high up in abdomen. Pain was so severe that he had to quit work. Fainted while attempting to remove overalls. A doctor was sent for who told him that there was nothing much the matter but that he should go home. Police ambulance was sent for, but when it arrived ambulance physician told patient that he should go immediately to the hospital.

The case was diagnosed gallstone colic, severe gastritis, appendicitis and perforating ulcer of the stomach. Operation revealed a very small perforating duodenal ulcer.

In this case the absence of any previous severe attacks of pain was against gall-stone colic. Food relief of pain, periodic attacks of stomach trouble, point to duodenal ulcer. This, together with the sudden onset and prostrating character of the pain, made the diagnosis fairly certain.

Fourth: Angina Pectoris or Syphilitic Angina with Diagnosis of Ulcer or Probable Cancer of Stomach.

Mrs. C., age 65 years; widow for 19 years. Father died of nephritis at 79 years. Mother died of old age at 79 years. Patient oldest of ten children, all living and well.

Past history: Childhood diseases negative. Never any serious illness until present trouble. Married at 19. Six children ranging from six to forty-six and all well. Menopause at 52.

Present illness: Past year and one-half, pain or a "cramp" in the pit of stomach, extending through to back and into both arms, but mostly down left arm into tips of fingers. Food does not give pain relief and patient is not sure that it increased the pain, but is afraid to eat because she thinks it does. When the pain is severe the choking sensation persists. Any exertion such as climbing elevated stairs increases pain. Sleeps poorly, pain worse at night. Pulse 116, temperature 98.4, blood pressure 150 systolic and 110 diastolic. Pupil reflex normal, throat

clear; lungs normal; heart slightly enlarged to left with mitral leak; abdomen negative. Could not obtain patella reflex. Appropriate treatment for the heart relieved the pain.

The pain extending down the left arm into the fingers, the pain being induced by exercise, were two diagnostic points in this case.

Fifth: Pneumonia and Appendicular Abscess.

Master J. S., age 12 years; schoolboy; white; entered the hospital with a diagnosis of appendicitis. The following history was given: Awakened one morning with pain in belly, vomiting several times. Pain subsided slightly after the first two days, but did not disappear and last three days had been worse, extending up into right side of chest. Patient had been sick six days prior to entering the hospital.

Physical examination: Temperature 103.4, respiration 48, friction rubs in right axillary region, systolic murmur at apex and radiating to axillary line with some enlargement of heart to left. Right lung nearly all solid, left lung fairly clear. Abdomen tympanitic with marked tenderness and rigidity over region of appendix. Leucocyte count 33,200. Urine contained one plus albumin in two specimens and granular casts in one and hyaline in the other. Pulse 142 and thready.

This patient was given the Ochsner treatment for one week when his temperature was down to 99.6 a. m. and 101 p. m.; pulse 90 to 110; respiration 22 and his lungs were much improved. On the eleventh day after entering the hospital his appendix was removed and the abscess cavity drained. He had a rapid recovery.

This case illustrates the fact that we can have a pneumonia very soon after the onset of an appendicitis, most likely caused by the same germ, although we were not able to get any sputum to prove it. If this pneumonia had followed the operation, we would surely have called it an ether pneumonia and blamed the anesthetist for it.

The pneumonia might not have been discovered if a careful examination of the chest had not been made.

I wish to close with a plea for the following:

1. A very careful and minute history obtained when possible from the patient as well as from the attending physician and family. This often requires time, but if correctly obtained, is worth more than 50 per cent. in the diagnosis.

2. A thorough physical examination of patient.

3. Clinical laboratory examinations.

4. When necessary, x-ray laboratory reports by a *competent roentgenologist*. X-ray pictures and reports may at times be very misleading unless made by competent workers.

4654 Sheridan Road.

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State society will pay no bills for legal services except those contracted by the Committee. Notify the Chairman at once. Do not employ attorneys.

MARCH, 1919

LET THE MEDICAL PRACTICE ACT ALONE.

Two years ago Governor Lowden, being greatly interested in a wise and economic administration of state affairs, asked for a new administrative

code and a new Medical Practice Act to correspond with it. In the passage of these measures he asked the assistance of the medical profession.

The profession at that time expressed its confidence in Governor Lowden, and through its representatives assisted in framing that portion of the Administrative Code applying to the Medical Practice Act and also in framing a Medical Practice Act, which at that time appeared to be the best from the viewpoint of the public good. It was deemed fair to all who wished to practice the art of healing, and at least one of the drugless cults was much pleased with the measure as passed.

Since then two years have gone by. We have seen the workings of the new law and have worked under it. It has proven satisfactory, and is pronounced the best Medical Practice Act on the statutes of any state.

The laws prohibiting stealing are not satisfactory to the man who has committed theft. The committing of theft is not for the well-being of the people; consequently the law which prohibits stealing. No law could be enacted which would be entirely satisfactory to all people. If so, there would be no need of such law.

The Medical Practice Act, which was enacted for the benefit of the public, has operated for two years and has been found satisfactory by the public and by the great majority of those individuals for whose regulation it was enacted. This statement will not be disputed except by a very small minority of those individuals whom the law regulates. Therefore, why open the law for amendments, which has been operative for so short a time and has proven satisfactory to the public?

In an analysis of the situation we find that the cult of drugless healers, known as Chiropractors, wish it amended, so that illiterate people may be licensed to practice Chiropractic in Illinois, and by the aid of a "joker" in another proposed amendment may, with almost no qualifications, be admitted to practice medicine in Illinois. The Optometrists, whom no one admits are capable of treating diseases of the eye, also want the act opened that they may have special favors.

In addition to these two minority factors, there is also another source of antagonism to the present Medical Practice Act, and that is the administrative office of the law, namely, the director of registration and education, and his first assist-

aut. Just why the director of registration and education or the superintendent of registration should be interested in having the Medical Practice Act opened at this time needs more explanation than has been made public. In fact, if they were supporting the administration of Governor Lowden they should be anxious that the Practice Act remain as it now is. We believe that since the profession assisted the Governor through its representatives to get a good Medical Practice Act in force, and since it is proving so satisfactory, the Governor should see that at least his own appointees stop meddling.

There is no reason why the Medical Practice Act should be opened up for amendment at this time. The law is fair to all as it is, and if any change were to be made, in our opinion, it should be made more comprehensive and include and regulate all cults who are practicing the healing art, excluding none.

Again we reiterate the Medical Practice Act should not be amended, and we urgently request the Governor to use his influence against the introduction of any amendments which may be offered.

THE PSYCHOPATHIC INSTITUTE AT KANKAKEE AND RESEARCH.

It will be a shock to most members of the Illinois State Medical Society to read the plea of Dr. Holmes in another column, and discover that the Institute at Kankakee has failed in pursuing vigorous researches into the causes of the insanities for which it was established in 1907. We cannot believe, because we would not believe, that the matter is judicially and fairly stated. We surmise that in his ardor for progress, Dr. Holmes has exaggerated the collapse of the Institute in this function. Although every physician in the state would contend for a much more munificent support of experimental investigations into the cause of the insanities, it is impossible to believe that for twelve long years the most promising work of the institution has been allowed to dwindle and fade away.

It is evident that the present director of the Department of Public Welfare, and his associates, are determined to put the Psychopathic Institute on a broader basis, a fact which our zealous advocate has completely ignored.

In the First State Budget covering the pro-

posed appropriation for the next biennium, \$333,542.00 is asked for the Psychopathic Institute. This is accompanied by the announcement of the consolidation of the existing Institute with the criminologist and alienist division and that "a considerable increase in appropriations is made to permit the carrying out of an enlarged program of preventive, curative and after-case methods, and also the proper classification of delinquents." We have not before us the details of this new departure which are filed with Department of Finance, and we must confess that we have some perturbations of spirit over the new functions of the institution, and fear that in the multitude of social busybodies and stirpigenous etiological investigators of crime and criminals, rational research will be completely extinguished.

If one hundred sixty-six thousand dollars a year were devoted to psychiatric research alone, it would undoubtedly meet universal approval of medical men in the state.

FREE WASSERMANN TESTS.

The editor has for a long time been much opposed to the multiplication of free medical institutions. Undeniably some are needed, but that the others are pauperizing agencies, none, we believe, will deny.

A short time ago we discussed in these columns the free venereal clinic, instituted by the director of public health. The Department of Public Health immediately denied any intention of giving general free treatment. Those able to pay would be charged for treatment or sent to regular physicians. We do not remember just when the state laboratories for giving Wassermann tests were organized, but at that time the same statements were made. They were only to take care of those unable to pay.

In this issue under "Public Health Notes," read about the "Free Wassermann Tests." It brazenly states, "The Diagnostic Laboratories of the State Department of Public Health are now making Wassermann tests without charge, regardless of the financial condition of the patient."

We run the note not for the advantage of our readers, but to inform them that the department is going just as far and as fast toward the abolition of the physicians' legitimate field of work as it possibly dares. It is our judgment that the sooner the profession expresses its opinion about

the organizing of the many free medical charities by the Department of Health, just as it is now doing in regard to annual registration, proposed by the Department of Registration, the more effectually will it check the undue activities of the medical director. Already, judging from the many pamphlets and other literature scattered broadcast over the state by the department, one might think the State Department of Public Health was a big eleemosynary institution. We have never had the opinion that such was its function.

NURSING BILLS

There have been two bills presented to the Legislature which are of vast importance to the public welfare, which also interest the medical fraternity and which are vital to hospitals. We refer to the two bills proposed for the regulation of the training of nurses and nursing the sick.

House Bill No. 151—Senate Bill No. 116—is the bill being urged by the nurses' association, or rather some of its officers, as the bill is not popular even among the nurses. This proposed measure is wrong all the way through. It is inhuman; it is obnoxious.

Briefly the bill provides that an applicant must have at least one year of high school; after 1924 they must have graduated from high school. To qualify as a registered nurse, one must have completed a twenty-seven months' course of training in a reputable training school. This bill also provided for a junior nurse, who has had at least one year of high school and has completed a training course of eighteen months. The junior nurse may nurse the sick or disabled, but may neither engage in public health nursing nor act in any supervisory capacity. She must be under the supervision of a registered nurse, subject to the authority of such registered nurse; and no provision is made for her ever emerging from such slavery. The bill makes it unlawful for any but a registered nurse or junior registered nurse to do nursing outside of one's immediate family.

Surely the devotees of the nursing act, who are responsible for this bill, have forgotten the prime or basic principle advocated by their predecessors. The measure is extremely detrimental to public welfare and should be defeated.

The other bill, House Bill No. 174—Senate Bill No. 124—is the bill advocated by the Illinois

Hospital Association. It is very acceptable, and at least considers humanity in permitting others than trained or registered nurses to care for the sick.

Briefly the measure provides for an applicant having completed a grammar school course. A twenty-four months' training course in a reputable training school for nurses is required before being qualified as a registered nurse.

This measure, if passed, will materially aid in supplying competent nurses for all purposes. The bill is a good one and should be supported.

Read Dr. M. L. Harris' criticism in this issue.

CHIROPRACTOR BILL.

House Bill No. 232, introduced by Mr. Stubbles of Peoria, is a bill permitting almost any one to practice chiropractic, and taken in connection with the proposed amendments to the Medical Practice Act of Mr. Dodds, superintendent of registration, will, with an examination in five branches, permit chiropractors to practice medicine in all its branches in Illinois.

This bill is so exactly similar in phraseology to the proposed amendments to the Medical Practice Act that it is convincing evidence that the two bills were written by one and the same author. Mr. Dodds claims authorship for the amendment to the Medical Practice Act.

The bill is vicious and should be defeated. Aside from several "jokers," we note that almost any one may practice under its provisions. There are practically no preliminary requirements and no length of course of study is stated, so that one or two or three months in a school of chiropractic is all that is necessary for licensure. This measure, if passed, will immediately fill all the chiropractic schools of Illinois with persons of little preliminary education. The course of study prescribed is so indefinite that it means nothing.

Section 11 of the bill offers reciprocity for all chiropractors. They may come from everywhere.

There is no reason why the chiropractor should have a special door opened to him by which he may practice medicine. The profession should be up and doing to prevent this measure being made into a law.

PUBLIC RELATIONS COMMITTEE,
Chicago Medical Society.

THE NURSING SITUATION.

REMARKS BY M. L. HARRIS, M. D., AT CITY CLUB, FEBRUARY 25, 1919.

In order that there may be no misunderstanding as to my position, I should like to preface my remarks with the statement that I have never said anything and shall say nothing here today that can in any way be construed as meaning or implying that I in the least underestimate the value of education. I have always stood for the highest degree of education possible, and I am so convinced of its importance that I look upon education as the one and only means of the salvation of the people. But we are not here today to discuss education. We are here confronted with a concrete problem of the greatest importance imaginable to the welfare of the sick.

All will admit that the sick and disabled should be properly taken care of. All must admit, too, that for some time past the difficulty of securing someone to care for the sick has been constantly increasing, and that during the recent epidemic thousands were obliged to suffer and many to die on account of the impossibility of securing someone to wait on them during their illness. That this unsatisfactory condition be remedied is the earnest wish and resolute demand of the people. With this crisis before us, the Illinois State Association of Graduate Nurses has come before the people with a bill, which has been introduced in the legislature and which the president of the association characterizes as "an honest effort to try to remove some of the nursing difficulties of the State."

If the passage of this bill will bring to the people the help which is so much needed in time of sickness, then it is a good bill, and should be supported; but if it will not bring the relief demanded, it should be defeated and a bill passed that will give to the people that which they so much need. Do not lose sight of the fact that the great desideration is more nurses who are willing to wait on the sick. At the present time the nursing force of the State is made up of registered nurses, graduate nurses, under-graduate nurses, sisters, deaconesses, and brothers of religious organizations who maintain and conduct hospitals and nurse the sick at their homes, so called "practical" nurses, and male nurses, and Red Cross and First Aid nurses, who have taken short courses preparing them to render assistance to

the sick and injured in time of need. Even this large force has been found to be insufficient.

There are in the state of Illinois approximately 6,300,000 people. Morbidity statistics show that of this number 2,100,000 will be sick or injured every year. The majority of these will be ambulatory patients, but of that number 525,000 will be bed patients, and they will average 21 days each in bed, or a total of 11,025,000 sick days in bed during the year. This number divided by 365, the number of days in a year, gives us 30,205 as the average number of persons sick every day in the year in this state. And every one of those patients needs to be waited on.

The first paragraph of the Nurses' Bill, which is said to be an "effort to remove some of the nursing difficulties in the state," reads that it shall be unlawful for any person to nurse the sick who is not a registered nurse, or a junior registered nurse. As there are no junior registered nurses at present, and as under the proposed bill it will take a year and a half after its passage before there can be any, it can be readily seen that the nursing force would be reduced immediately to the registered nurses. There are in the state, according to the latest available figure, only 3,200 registered nurses. Many of these are doing institutional and other work, or have left the state and are not waiting on the sick, but if every one of them were to nurse some patient every day in the year, there would still be over 26,000 patients sick every day in the year who would be unable to secure anyone to wait on them, for all the unregistered nurses, the sisters and deaconesses and brothers, all the male nurses, and the practical nurses, and the Red Cross and First Aid helpers, would be prohibited from nursing, either for hire or gratuitously.

Nor is this all. There are now approximately 67,000 births annually in the city of Chicago alone, allowing the very low average of ten days rest in bed after a confinement. This means that there are nearly 2,000 women in bed needing the care of someone every day during the year: 65 per cent of these women are nursed at this time by practical nurses. Who is to wait on these women and help them look after their babes when the practical nurse is prohibited by law from doing it?

With so much sickness constantly present, could a law that would make it impossible for this great mass of suffering humanity to secure

nursing be called humane? Again, in the state of Illinois there are over 1,050 incorporated cities and towns, while there are only 666 nurses registered in the whole state outside of the city of Chicago. As most of these registered nurses are in the larger cities, it is very evident that there is not a single registered nurse to be found in the great majority of the towns of the state. What are the people of these towns to do with their sick if no one but a registered nurse is to be allowed to wait on them? Are these people to be compelled to suffer unattended, or with only such help as may be rendered by members of the family, or friends? Such an absurd proposition would be ludicrous were it not so inhuman.

This proposed Nurses Bill provides for the creation of a new group of nurses with 18 months' training, to be called Junior Nurses. The intention is to make these Junior Nurses do all the work of waiting on the sick, while the real registered nurse is to boss the job. The president of the State Association of Registered Nurses in a letter which has recently been sent out, says: "To assure the 18 months' nurse being kept for the bedside care of the sick," a restriction has been placed in the law preventing her from doing anything else. This restrictive paragraph in the bill reads as follows: "A Junior registered nurse may nurse the sick or disabled, but may neither engage in public health nursing, act in a supervisory capacity in a hospital or similar institution, act as an instructor or in a supervisory capacity in a school of nursing, nor act as an instructor or in a supervisory capacity in public health service or any other like service." She is not even permitted to nurse in a hospital except "when under the immediate personal supervision of registered nurses."

Another paragraph of the bill provides that the registered nurse may do all those things which are forbidden to the Junior Nurse. It makes no difference how much more natural ability the Junior Nurse may have over the registered nurse, the mere fact that the law has branded her a "junior" prohibits her from doing those things which the registered nurse wants to do, and is made to do the work which the registered nurse does not want to do. The Junior, by hard work and application and experience, might acquire a fund of knowledge that would make her a most excellent instructor. She might show remarkable ability as an executive, or display great

aptitude for public health or social service work, yet she must curb all her ambitions, for the proposed bill says that she may not do any of those things.

Can anyone imagine anything more uncalled for, more unnatural, more undemocratic, more un-American, more unjust, more unbearable, or more unconstitutional, than for the law to attempt to prohibit an individual to make use of his normal talent in a perfectly legitimate manner, for his own improvement and betterment in life?

It is claimed that a Junior may at some future time become a real registered nurse, but when? How? The bill makes no provision for any such thing. On the contrary, it sets up a barrier that few, if any, will be able to scale. Knowledge gained by experience in the practice of nursing is to count for naught. Perhaps on account of having been less favored by fortune in early life, and thus not having had all the preliminary educational advantages enjoyed by some, the Junior is to be condemned by law to play the part of a slave to the more favored few.

At a recent conference with a group of those who are responsible for the provisions of the Nurses Bill, I asked what it was that was taught in the high school that was so essential that without it no intelligent girl could ever learn to wait on the sick and carry out a physician's orders. A painful silence reigned supreme. After repeating the question one of the group finally replied that it was algebra, and said that she thought it impossible for any intelligent girl to grasp the ponderous problems of nursing without a knowledge of algebra. I refrained from asking any of those present to resolve a simple algebraic equation. Algebra is a very useful and important branch of mathematics, and a knowledge of it is essential to those engaged in certain occupations. but is there any sense in saying that a girl can't become a nurse because she is unable to explain the principles of binomials or logarithms? There would be no more sense in that than there would be in the converse statement that a girl who could explain these principles has too much knowledge to nurse. It would be absurd to determine a girl's fitness to take up nursing by her knowledge of algebra, something she would never use, for she might know all about that and much more and yet not have practical sense enough to

give a patient in bed a drink of water without strangulating him to death. This is not to be construed as an argument against education, but as an argument against making the possession of unessential knowledge as a preliminary requirement for an otherwise well qualified girl who wishes to take up the occupation of nursing.

SECRETARIES OF COUNTY SOCIETIES.

There are many serious complaints of county secretaries' failure to reply to communications addressed to them. One complainant states that out of 303 letters addressed to county secretaries, but 35 replies were received.

The state secretary's office has trouble in getting reports from county secretaries, and this makes trouble in the membership lists. If the county secretary does not report and remit for a member, that member is not in good standing.

These complaints do not apply to all secretaries, as many of them are very prompt. A little more effort on the part of several of the county secretaries will help very materially. Please help along, Mr. Secretary.

EYE, EAR, NOSE AND THROAT SECTION.

The officers of the section of the Eye, Ear, Nose and Throat have completed all arrangements for the coming meeting of the section at Peoria, Tuesday and Wednesday, May 20 and 21, 1919. This will be a meeting well worthy of attendance.

Tuesday, May 20, 1919, will be Clinic day. The entire clinical program will be carried on at St. Francis hospital, beginning at 9 a. m., adjourning at 12 o'clock for luncheon, and resuming promptly at 1:30 p. m., continuing until 5 p. m. The local clinical committee at Peoria have already under way a clinical program which will in variety and from an operative standpoint command the interest of every member of the section. Some of the most distinguished members in our specialty will perform operations and make demonstrations of interesting clinical cases. The members are urged to present any case of interest to the section on this occasion.

Tuesday evening, May 20, 6:30 p. m., the annual banquet will be held. All the members are especially invited to be present. The local committee are making preparations to give us a delightful evening. It is a noticeable fact that all who ever attend one of our great get-together

evenings could not be induced to miss them thereafter. It will cheer you up for a year to come.

Wednesday, May 21, will be devoted to reading papers. The program will begin promptly at 9 a. m., and continue until 12 o'clock, resume at 1:30 p. m., and continue until 5 p. m. The officers have prepared a strong and interesting program, both essayists and subjects have been selected with the utmost care. No effort has been spared to present a program of wide range and scientific value covering the most interesting and important phases of progress in our specialties. In addition to the reading of papers, a special time has been allotted to presentation of pathological specimens, microscopical demonstrations, instruments and devices. Any member who wishes to make such a demonstration is requested to communicate with the secretary or chairman.

It is the earnest wish of the officers of the section that the attendance at the coming meeting will surpass that of any meeting heretofore held.

The officers of the section and local committee at Peoria have with enthusiasm and earnestness made every preparation to make this meeting the banner meeting of our section, and their preparations for the clinic, banquet and scientific program have been carried out with the certain idea that this standard will be attained. It only remains for the section members to show their co-operation by their attendance and interest in order that this result may be attained.

WESLEY HAMILTON PECK, Chairman,
31 N. State Street, Chicago, Ill.

FRANK ALLPORT, Secretary,
7 W. Madison Street, Chicago, Ill.

VENEREAL DISEASE PRESCRIPTIONS.

Resolved, that the Council of the Chicago Medical Society disapproves of the wording of a recent communication from the United States Public Health Service and urges all members to erase the first part of sentence of Section 3 before signing and returning the same. Said section reads:

I do specifically agree not to dispense medicine which I prescribe in venereal cases, except when they can not be obtained from a drug store.

Moved and seconded that this resolution be adopted and that a copy of same be published in the BULLETIN and in the ILLINOIS STATE JOURNAL. Carried.

PROPOSED CHANGES IN THE MEDICAL
PRACTICE ACT, WITH A FEW CRIT-
ICISMS BY THE PUBLIC HEALTH
COMMITTEE OF THE CHICAGO
MEDICAL SOCIETY.

The following proposed bill emanates from the Department of Registration and Education and was obtained in person from Mr. Dodds, superintendent of registration, who admitted at a public hearing in Chicago, February 1st, that he represented the Department of Registration and Education and wrote the proposed changes in the Medical Practice Act. It was discussed by Mr. Shepardson, Mr. Dodds and several representatives of the medical profession. While the proposed bill vitally concerns the medical profession. Mr. Dodds stated that "no doctor had a hand in its authorship and that the medical profession was never consulted in any way as to any of the provisions of the proposed bill."

A BILL

For AN ACT to amend Sections 5, 7, 13, 14, 15, 16, 17, 18, 19, and 22 of An Act entitled "An Act to revise the law in relation to the practice of the art of treating human ailments," approved June 25, 1917, and in force July 1, 1917; and to add thereto a new section to be known as Section 26a.

Section 1. *Be It Enacted by the People of the State of Illinois, represented in the General Assembly:* That Sections 5, 7, 13, 14, 15, 16, 17, 18, 19, and 22 of an Act entitled "An Act to revise the law in relation to the practice of the art of treating human ailments," be amended and that there be added to said Act, a new section, to be known as Section 26a, said sections when amended and said new section to read as follows:

Section 5. Minimum standards of professional education are fixed as follows:

1. For the practice of medicine and surgery in all their branches.

(a) For an applicant, who is a graduate of a medical college prior to July 1, 1922, that he is a graduate of a medical college deemed to be reputable and in good standing at the time of his graduation and completed a course of study in such medical college in accordance with the laws to regulate the practice of medicine and the rules of the State Board of Health established and in force at the time of *matriculation*.

(b) For an applicant, who is a graduate of a medical college subsequent to July 1, 1922, that he is a graduate of a medical college deemed to be reputable and in good standing and which requires of its students, as a prerequisite to graduation, either at least five years' course of instruction, the time elapsing

between the beginning of the first year and the ending of the last, or fifth year, in the medical college to be not less than fifty months, or, as a prerequisite to admission to such medical college, one year in a college of liberal arts approved by the Department of Registration and Education, and pursuing in such college of liberal arts a course of study approved by such department, and at least four years' course of instruction in the medical college, the time elapsing between the beginning of the first year in the medical college and the ending of the last or fourth year in the medical college to be not less than forty (40) months, and, in either case, in addition thereto, a course of training of not less than twelve months in a hospital or laboratory approved by the Department of Registration and Education;

2. For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery; that the applicant is a graduate of a professional school, college or institution teaching the system of treating human ailments for which the applicant desires to be licensed, which requires as a prerequisite to graduation four years' course of instruction, the time elapsing between the beginning of the first year and the ending of the last, or fourth year, to be not less than forty months, and which is deemed to be reputable and in good standing;

3. For the practice of midwifery: That the applicant is a graduate of a college of midwifery in good standing.

The standards of professional education above defined shall be deemed to be minimum requirements. The Department of Registration and Education may, by rule, prescribe other and additional requirements for professional education.

Section 5, paragraph b. Criticism:

On its face this provision is absurd, as no laboratory can take the place of the clinical advantages of a year's internship in a hospital.

Section 7. Minimum standards of preliminary education deemed requisite to admission to a medical college, or to a professional school, college or institution teaching other systems of treating human ailments, deemed to be reputable and in good standing, are fixed as follows:

1. That the applicant for admission to such college, school or institution has satisfactorily completed an approved course of study in a high school or other equivalent school having a course of studies requiring an attendance through four school years and which is approved by the Department of Registration and Education.

2. That the applicant present a certificate of having passed a satisfactory written examination before the *Department of Registration and Education*, or *before the Commissioner of Education* or like state officer of another state or country, in the studies

embraced in the curriculum of a high school approved by the Department of Registration and Education.

The Department of Registration and Education shall collect in advance a fee of five dollars (\$5.00) from each applicant for examination.

Section 7. Criticism:

Clearly an effort by Mr. Shepardson to be dictator of the public schools and the entire educational system of Illinois, arrogating to himself the prerogatives of the Superintendent of Public Instruction. Such concentration of power in one department is inimical to the public good.

Section 13. Each applicant who successfully passes an examination shall be entitled to a license. The following kinds of licenses shall be issued:

1. To practice medicine and surgery in all their branches to those who took an examination for that purpose.

2. To treat human ailments without the use of drugs or medicine and without operative surgery, to those who took an examination for that purpose, and to practice such treatment in accordance with the tenets of the school of practice designated by applicant under the provisions of section four (4) of this Act.

If the applicant successfully passed the examination in the subject of midwifery, the license shall also set forth his right to practice midwifery.

3. A limited license to practice medicine and surgery in a hospital approved by the Department of Registration and Education.

4. To practice midwifery.

5. *The holder of a license issued in pursuance of and under any law of this state to practice medicine and surgery in all its branches or to practice any other system or method of treating human ailments without the use of drugs or medicine and without operative surgery, or to practice midwifery, shall conspicuously display the same in his or her place of business or employment.*

Section 13, paragraph 5. Criticism:

Impossible to comply with this section unless a physician has more than one license.

Section 14. Any person licensed under the provisions of this Act to practice in any school or system of treating human ailments without the use of drugs or medicines and without operative surgery, may be admitted to take an examination to practice medicine and surgery in all their branches upon proof of having successfully completed, in a medical college deemed to be reputable and in good standing, the course of study required for admission to an examination in materia medica, therapeutics, surgery, obstetrics, and theory and practice only, and in no other subjects. In case the applicant holds a license to

practice midwifery, he shall be credited therewith and shall be examined in obstetrics in that portion which was not included within the scope of his examination in midwifery. If the applicant successfully passes such examination he shall be issued a license to practice medicine and surgery in all their branches.

Section 14. Criticism:

By cunningly worded change, omission and tricky transposition, this section makes it easy for those who hold limited licenses to obtain the title of M. D. with all its privileges, without having taken the full course required of all regular medical students. The omission of pathology, bacteriology, chemistry, diagnosis and other fundamentals provides a short cut for irregulars to obtain licenses to practice medicine in all its branches.

Section 15. The Department of Registration and Education may, in its discretion, issue a license, without examination, to a practitioner who has been licensed in any country, state, territory, or province upon the following conditions:

1. That the applicant is of good moral character.

2. That if the applicant desires to practice medicine and surgery in all their branches.

- (a) He is a graduate of a medical college in good standing.

- (b) The requirements of medical registration in the country, state, territory, or province in which he is licensed are deemed by the Department of Registration and Education to have been practically equivalent to the requirements of medical registration in force in this State at the date of such license.

3. That if the applicant desires to treat human ailments without the use of drugs or medicines and without operative surgery:

- (a) He is a graduate of a professional school, college or institution in good standing.

- (b) The requirements of registration to practice the treatment of human ailments without the use of drugs or medicines and without operative surgery are deemed by the Department of Registration and Education to be practically equivalent to the requirements of such registration as provided for under this Act.

The Department of Registration and Education may also, in its discretion, issue a license, without examination, to a physician who is a graduate of a medical college in good standing, and who has passed an examination for admission to the medical corps of the United States Army, the United States Navy, or the United States Public Health Service.

Applications from non-resident practitioners shall be filed with the Department of Registration and Education on blank forms prepared and furnished by the Department.

Section 15, paragraph 4, of the present Medical Practice Act is omitted and is quoted as follows:

"That the country, state, territory or province in which the applicant was licensed shall accord a like privilege to physicians, or to those who hold licenses to treat human ailments without the use of drugs or medicines and without operative surgery, who hold licenses under the authority of the laws of this state."

Section 15. Criticism:

The omission of paragraph 4 of this section robs the Medical Practice Act of its reciprocity feature, and opens the way to licensure in Illinois to all forms of practitioners, without the physicians of Illinois enjoying like privileges in other states. Anyone wishing a short cut into the practice of medicine can get a limited license in another state and by passing an examination in five branches in Illinois, become a full fledged M. D. with all its privileges. That this omission is not an oversight, but is deliberate, is shown by the fact that Section 16 is correspondingly altered. Not only is reciprocity, but the word "reciprocity," is eliminated by the proposed changes in the Medical Practice Act.

Section 16. Each person entitled to a license under this Act or a certificate of renewal of registration, shall pay to the Department of Registration and Education the following fees:

1. For a license to practice medicine and surgery in all their branches, or for a license to practice any other system of treating human ailments, five dollars;
2. For an annual certificate of renewal of registration to practice medicine and surgery in all their branches, or for an annual certificate of renewal of registration to practice any other system of treating human ailments, two dollars;
3. For the restoration of an expired certificate of registration to practice medicine and surgery in all their branches, or for the restoration of an expired certificate to practice any other system of treating human ailments, five dollars;
4. For a license to practice midwifery, three dollars;
5. For an annual certificate of renewal of registration to practice midwifery, one dollar;
6. For the restoration of an expired certificate of registration to practice midwifery, three dollars;
7. For a limited license to practice medicine and surgery in a hospital approved by the Department of Registration and Education, five dollars, and no fee for issuing to the holder of such limited license a permanent license;
8. For a license to a practitioner admitted from a foreign state or country under the provisions of Sec-

tion 15 of this Act the same fees charged by the state endorsing the applicant for an Illinois physician applying for registration in such state, but in no case less than twenty-five dollars.

Section 16. Criticism:

Section 16 is an elaboration of the fee system, intended to magnify the importance of this department when measured in dollars and cents, the dominant feature of annual registration.

Section 17. *Every person holding a license to treat human ailments in all its branches, or to treat human ailments without the use of drugs or medicines, and without operative surgery, or to practice midwifery shall, annually, on or before the first day of January, renew his certificate of registration and pay the required fee. Every certificate of registration which has not been renewed before the first day of February in any year shall expire on that day. An expired certificate may be restored only upon the payment of the required restoration fee.*

Any person who retires from the practice of his profession for not more than five years may renew his or her certificate of registration upon the payment of all lapsed renewal fees.

Section 17. Criticism:

The proposed annual expiration of the right to practice medicine as asked by the department is an outrage upon the medical profession. Confiscation of licenses or so-called annual registration is nothing short of outrageous. No physician is willing that a layman, who may be an Eddyite, osteopath, chiropractor or Dowieite, shall sit in judgment annually on his right to practice medicine.

Section 18. *The Department of Registration and Education may either refuse to issue, or may refuse to renew, or may suspend, or may revoke, any license or certificate of renewal of registration issued in pursuance of and under any law of this state to practice medicine and surgery in all their branches, or to practice any other system or method of treating human ailments without the use of drugs or medicine and without operative surgery, or to practice midwifery, for any one, or any combination, of the following causes:*

1. A person who has been convicted of the practice of criminal abortion;
2. A person who has by false or fraudulent representation obtained or sought to obtain practice in his profession;
3. A person who is an habitual drunkard, or habitually addicted to the use of morphine, opium, cocaine or other drugs having a similar effect;
4. A person who has by false or fraudulent repre-

sensation of his profession obtained or sought to obtain money or any other thing of value.

5. A person who has advertised under a name other than his own;

6. A person who shall advertise or profess publicly to treat human ailments under a system or school of treatment or practice other than that for which he holds a license;

7. A person who has been committed, by the judgment of a court of competent jurisdiction, to a hospital for the insane;

8. A person who is guilty of any wilful violation of the rules and regulations of the Department of Registration and Education governing examinations, or who is guilty of any fraud or deceit by which he was admitted to practice;

9. *The violation of, or the procuring of, or assisting in the violation of, any act which is now or which may hereafter be in force in this state relating to the use of habit-forming drugs;*

10. *Conviction of a felony as shown by a certified copy of the record of the court of conviction;*

11. *Gross malpractice;*

12. A person who has been guilty of any other unprofessional or dishonorable conduct.

Paragraph 6 of this section shall not be construed to affect any person licensed by the State Board of Health, on or before July 1, 1917, to treat human ailments without the use of drugs or medicines internally or externally and without the use of operative surgery, who is legitimately engaged in the practice of his profession, unless he shall treat, or profess to treat human ailments with the use of drugs or medicines, internally or externally, or with operative surgery.

The Department of Registration and Education may neither refuse to issue, nor renew, nor suspend, nor revoke, any license or certificate of renewal of registration issued in pursuance of and under any law of this state to practice medicine and surgery in all their branches, or to practice any other system or method of treating human ailments without the use of drugs or medicine and without operative surgery, or to practice midwifery, unless the person accused has been given at least 20 days' notice, in writing, of the charge against him, and a public hearing by the Department of Registration and Education.

Upon the hearing of any such proceeding, the Director of Registration and Education, the Assistant Director of Registration and Education, or the Superintendent of Registration, may administer oaths, and the Department of Registration and Education may procure, by its subpoena, the attendance of witnesses and the production of relevant books and papers. The accused may have the subpoena of the Department of Registration and Education for his witnesses, and may be heard in person and by counsel, in open public hearing.

Any circuit court, or any judge of a circuit court, either in term time or in vacation, upon the application, either of the accused or of the Department of Regis-

tration and Education, may, by order duly entered, require the attendance of witnesses and the production of relevant books and papers, before the Department of Registration and Education in any hearing relating to the refusal, suspension or revocation of certificates of registration. Upon refusal or neglect to obey the order of the court or judge, the court or judge may compel, by proceedings for contempt of court, or otherwise, obedience of its or his order.

Section 19. The Department of Registration and Education shall have power, and it shall be its duty:

1. To make rules to establish a uniform and reasonable standard of educational requirements to be observed by medical colleges, or professional schools, colleges and institutions teaching other systems or sciences of treating human ailments without the use of drugs or medicines and without operative surgery, and by schools of midwifery, and to determine the reputability and good standing of such schools, colleges or institutions by reference to their compliance with such rules;

2. To require satisfactory proof that medical colleges and professional schools, colleges or institutions teaching other systems of treating human ailments, and schools of midwifery, which are deemed to be reputable and in good standing, enforce the standard of preliminary education deemed by this Act requisite to admission to such medical colleges, or to professional schools, colleges or institutions teaching other systems of treating human ailments, or to schools of midwifery;

3. To determine the standing of literary or scientific colleges, high schools, seminaries, normal schools, preparatory schools, graded schools and the like, whenever required by this Act.

4. *The Department of Registration and Education may adopt reasonable rules and regulations relating to the enforcement of this Act.*

Section 22. Any person who, not being then licensed to practice medicine and surgery in all their branches, shall practice medicine and surgery; or who, not being then licensed to treat human ailments without the use of drugs or medicines and without operative surgery, shall treat human ailments without the use of drugs or medicines and without operative surgery; or who, being licensed to treat human ailments without the use of drugs or medicines and without operative surgery, shall treat human ailments with drugs or medicines or with operative surgery; or, who, not being then licensed to practice midwifery, shall practice midwifery; or who shall buy, sell or fraudulently obtain any medical or professional diploma, license, or registration; or who shall fraudulently aid or abet such fraudulent buying, selling or obtaining; or who shall practice the treatment of human ailments, or midwifery under cover of any license fraudulently or illegally obtained; or, who, being licensed to treat human ailments without the use of drugs or medicines and without operative surgery in a named school or system of practice, shall, in connection with his name, advertise or profess to treat human ail-

ments under a system or school of treatment or practice other than that for which he holds a license, shall be guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not less than twenty-five dollars nor more than two hundred dollars, or confined in the county jail not more than one year, or punished by both such fine and imprisonment in the discretion of the court.

In every proceeding under the provisions of this Act an averment that the defendant at the time of the alleged defense was without the required license or certificate of renewal of registration shall be taken as true, unless disproved by the defendant.

Section 22. Criticism:

This reverses all established rules of law and justice that "a man is presumed to be innocent until proven guilty." According to the wording of Section 22, the mere "averment" by the department that a physician has committed a misdemeanor makes the case against any physician begin with a verdict of guilty. The burden of proof, the humiliation, and all trouble and annoyance are placed on the defendant. This reverses all rules of court procedure.* Should a physician's license be burned, he is guilty and his "best evidence" is ashes. The people of Illinois can have little confidence in a department of State government that would ask such despotic, unjust and unheard-of advantage in a contest where a physician stakes everything that he owns, his reputation—his means of making a living.

Section 26a. All fines and penalties collected under the provisions of this Act shall insure to the Department of Registration and Education.

Section 26a. Criticism:

No comment necessary. The language is very explicit.

MEDICAL SOCIETIES OPPOSE ANNUAL REGISTRATION

The following medical societies and medical organizations have voted to oppose annual registration of physicians:

The Council of the Illinois State Medical Society, January 21, 1919, unanimous.

The Council of the Chicago Medical Society, January 14, 1919, unanimous, with one exception.

Aux Plaines Branch of the Chicago Medical Society, January 24, 1919, unanimous.

North Shore Branch of the Chicago Medical Society, February 4, 1919, unanimous.

Douglas Park Branch of the Chicago Medical Society, February 18, 1919, unanimous.

Northwest Branch of the Chicago Medical Society, February 14, 1919, unanimous.

South Chicago Branch of the Chicago Medical Society, unanimous.

North Side Branch of the Chicago Medical Society, February 15, 1919, unanimous.

Fulton County Medical Society, unanimous.

Effingham County Medical Society, February 11, 1919 unanimous.

Christian County Medical Society, February 20, 1919, unanimous.

Boone County Medical Society, unanimous.

Adams County Medical Society, February 10, 1919, unanimous.

Madison County Medical Society, February 7, 1919, unanimous.

Peoria City Medical Society, February 4, 1919, unanimous.

St. Clair County Medical Society, February 6, 1919, unanimous.

Pike County Medical Society, January 30, 1919.

Jo Daviess County Medical Society, January 30, 1919, unanimous.

Marion County Medical Society, February 14, 1919, unanimous.

Winnebago County Medical Society, January meeting.

Crawford County Medical Society, February 13, 1919, unanimous.

Mr. Shepardson visited Kankakee County Medical Society but forgot to take a copy of his proposed bill with him. The Society, after discussion of the subject, decided to postpone action until Mr. Shepardson could present them a copy of his proposed bill.

WISCONSIN TURNS DOWN HEALTH INSURANCE.

The commission appointed by the last Wisconsin legislature to investigate the subject of the advisability of enacting Compulsory Health Insurance Laws in that state have reported adversely to the ideas.

A turndown for the project coming from this source has a double significance for the reason that for years Wisconsin has been characterized

as the experimental station of America of all the new thought ideas.

Ed. H. Ochsner,
Chas. J. Whalen, Chairman.
Geo. Apfelbach,
J. R. Ballinger, Secretary.

THE HARRISON ACT,

AS AMENDED by the new War Revenue Act. will be mailed postpaid to any druggist, physician, dentist or veterinarian who will send a postal request therefor to "Mailing Department, Parke, Davis & Co., Detroit, Mich." Please observe directions strictly.

TENTATIVE REPORT ON THE USE OF NEO-ARSAMINOL IN THE TREATMENT OF SYPHILIS.

I have administered Neo-Arsaminol in a sufficient number of cases of Lues in the various stages to recommend it as one of the best Aasphenamine preparations in the treatment of Lues. The skin lesions readily disappear and a positive Wassermann soon becomes negative.

So far, in the administration of this remedy I have observed less toxicity than with other Arsphenamines, consequently, it can be given in larger doses and more frequently administered. Neo-Arsaminol goes into solution readily in cold distilled water or 0.4 salt solution, without clumping or forming a sediment.

Neo-Arsaminol may be given in small concentrated doses and should be administered very slow (Ravant method) in a 2 to 20 c.c. syringe, or if preferred, by gravity, using a larger amount 75 to 150 c.c. of cold fresh distilled water, or 0.4 salt solution.

Temperature of water should be 25 to 30 degrees C. or 75 to 85 degrees F.

W. T. Mefford, M. D.

Public Health

PROPOSED LEGISLATION OF INTEREST TO THE MEDICAL PROFESSION

A large number of bills of interest to the medical profession have already been introduced at the General Assembly, some of them causing considerable difference of opinion on the part of those particularly affected. The principal bills introduced up to this time, in the order of their introduction in both the House and Senate, are as follows:

House Bill No. 4 provides that municipalities after referendum, may levy a special tax to erect and maintain public comfort stations.

House Bills, Nos. 39, 40 and 41 provide for the creation of a Board for Vocational Education to co-operate with the Federal Board for Vocational Educa-

tion in administering the provisions of the Federal law. These three bills differ only in the personnel of the board.

House Bill No. 42 authorizes municipal officials to make an appropriation in excess of the annual budget to meet the expenses incidental to epidemics, and to permit of the borrowing of money for this purpose.

House Bill No. 57 provides for the licensure of women as dental hygienists after a course of one year in a licensed dental school, such hygienists being authorized merely to clean the teeth under the direction of a dentist.

House Bill No. 64 requires physical examination for the detection of venereal diseases, as a prerequisite to the issuance of marriage licenses. The examination must be made by a physician residing in the County in which the license is granted, and within fifteen days of application for license. In case of a disputed diagnosis, laboratory diagnosis is to be made by the State Department of Public Health. Appeal will be made to the County Court, which is compelled to give hearing at once before a jury, if desired by the interested persons. This court decision is final.

House Bill No. 67 amends the law relative to public hospitals, providing that the measure need receive "a majority of the votes cast on the proposition", and authorizing the issuance of bonds to anticipate funds for a period not to exceed twenty years.

House Bill No. 73 makes provision for the tuberculin testing of cattle at the request of the owner, and appropriates funds for partly reimbursing the owner in case the cattle are diseased and condemned.

House Bill No. 74 provides for the creation of an Industrial Commission having the power to determine the proper working conditions and hours for women, after public hearing, and designating ten hours per day or fifty-five per week as the proper working hours for women until further determined by the Commissioner.

House Bill No. 80 provides for the examination and licensure of optometrists and apprentices for optometrists, exempting physicians, prescription spectacle houses and venders of spectacles with permanent places of business and not practicing optometry.

House Bill No. 102 provides for the medical inspection of all school children at the cost of school authorities; requires examination of sanitary condition of school buildings and surroundings; prohibits tuberculous teachers, pupils or employees being engaged in any school, except such special schools as may be conducted under the rules of the State Department of Public Health, and exempts certain children in poor health from the laws of compulsory attendance.

House Bill No. 147 amends the County Tuberculosis Sanitarium law so as to permit counties to unite in the erection of district sanitariums.

House Bill No. 151 to regulate the practice of nursing to require all nurses to be registered, and creating the classes of "registered nurse" and "junior registered nurse", and requiring renewal of registration each year.

House Bill No. 155 amends the Civil Administrative Code and provides for a board, under the Department of Registration and Education, for the purpose of betterment of living and health conditions of negroes.

House Bill No. 174 to regulate the practice of nursing and to establish standards for the licensure of registered nurses.

House Bill No. 175 amends the Civil Administrative Code so that the committee for registered nurses shall consist of two physicians, two registered nurses and one person connected with the administration of a hospital conducting a training school for nurses.

House Bill No. 177 provides for the determination of "good standing" for all university, college, professional or technical schools to be so recognized by all Departments of the State of Illinois.

Senate Bill No. 7 provides for physical training in all public schools, the employment of a physical instructor, and for the joining together of school districts for the purpose of employing such instructor.

Senate Bill No. 22 provides for a board for Vocational Education to cooperate with the Federal Board for Vocational Education for the purpose of obtaining benefits under the Act of February 23, 1917.

Senate Bill No. 29 provides for the establishment of a State Council of Reconstruction, Employment and Relief, to include experts in sanitation, public health, medicine and surgery to assist returned soldiers and sailors.

Senate Bill No. 75 authorizes municipalities to establish public comfort stations and levy a tax for this purpose after referendum.

Senate Bill No. 77 to authorize censorship of motion pictures by the State Department of Registration and Education, except those displayed by associations or institutions of learning, etc.

Senate Bill No. 80 requires all poor houses, alms houses and poor farms to be designated as "County Homes."

Senate Bill No. 82 provides for a fund to be known as a "Maternity Fund" to be expended by the county for the medical care, nursing, attendance and welfare of women at childbirth, and for the mother and child for a period of one year after childbirth.

Senate Bill No. 112 to amend the County Tuberculosis Sanitarium law and permit adjoining counties to join in the creation of tuberculosis sanitarium districts.

Senate Bill No. 116 to regulate the practice of nursing. Same as House Bill No. 151.

Senate Bill No. 123 reorganizes the committee for registered nurses in the Department of Registration and Education so as to be made up of two physicians, one hospital official and two nurses:

Senate Bill No. 124 to regulate the practice of nursing. Same as House Bill No. 14.

Senate Bill No. 125 to confer upon municipalities the power to create districts for residential and industrial purposes.

FREE WASSERMANN TESTS

As previously announced in these pages, the Diagnostic Laboratories of the State Department of Public Health are now making Wassermann tests without charge, regardless of the financial condition of the patient. Containers for the transmission of specimens are furnished upon application.

The Wassermann test as now carried out in the state laboratories under the direction of Martin Dupray, is as nearly perfect as it can be made at the present time. Two different antigens are used, each with control, and exact record is preserved of the protocol in each test. The cholesterin antigen is peculiarly sensitive. Positive results may be there indicated when there has been no infection, but positive results without alcoholic antigen may be considered as reliable proportionately to the percentage of fixation. Absence of positive results does not clearly demonstrate absence of the disease, for there are many chances for negative results. In diagnosis, therefore, positive results for the cholesterin antigen and negative with the alcoholic raises a suspicion which causes the case to be reported as doubtful.

By the methods now employed in the state laboratory possible sources of error are reduced to a minimum, and the records are kept in such manner that their full value may be properly considered in the light of possible future discoveries and improvements.

EDUCATIONAL WORK IN SOCIAL HYGIENE

The Division of Social Hygiene of the State Department of Public Health has completed a comprehensive educational program which will be carried out in the city of Chicago, and in all sections of the state. This program consists of lectures and motion pictures designated for both men and women, and the distribution of large numbers of circulars and other educational material dealing with venereal disease problems. This general campaign was definitely launched on February 23, which was designated as "Health Sunday" by the United States Public Health Service. On that day fifty thousand pamphlets on venereal diseases were distributed in Illinois.

The educational campaign designed for men will be carried out under the direct supervision of Dr. G. G. Taylor, Chief of the Division of Social Hygiene, lectures being delivered by twelve or more physicians selected for that purpose. The film, "Fit to Win," an up-to-date version of the film, "Fit to Fight," which was used in the military cantonments, will be generally employed.

The educational campaign for women will be under the general supervision of Dr. Rachelle S. Yarros of Chicago, formerly Chairman of the Social Hygiene Committee of the State Council of Defense, who has been appointed Supervisor of Education for Women.

The Division has been successfully active during the past month in securing the cooperation of the medical profession, local health officers and public welfare organizations for the purpose of opening venereal disease clinics in several cities of the state.

COMMUNICABLE DISEASES DURING FEBRUARY

During the past month, smallpox has been reported from a number of widely scattered communities throughout the state. In Leech township, Wayne county, twenty-nine cases were reported within a very few days, while twenty-eight cases were reported at Hillsboro, Montgomery county. Smallpox is also reported at Pekin, Arlington Heights, Salem, Urbana, Peoria, Rockford and American Township, Pulaski county.

At Geneva, Kane county, there has been an epidemic of dysentery similar to that which appeared at Peoria some time ago. The infection in this epidemic is supposed to be water borne.

Scarlet fever cases in more than ordinary numbers, have been reported at Mt. Sterling, Quincy, Naperville and Suez township, Mercer county, and in Seven Hickory township, Coles county. At Naperville, the disease appeared in Northwestern college.

The influenza epidemic seems to have subsided in all sections of the state excepting at DuQuoin and Robinson and in Bowling Green township, Fayette county and Independence township, Saline county, where large numbers of cases are being reported.

During the month, three cases of poliomyelitis were reported from Chicago and two cases of epidemic meningitis at Flora.

POLIOMYELITIS CLINICS AT FREEPORT

The Division of Child Welfare and Public Health Nursing of the State Department of Public Health, has established a clinic for the after-care of victims of poliomyelitis at Freeport, Stephenson county. Regular clinics are now being held at Springfield, Alton, Quincy, Rockford, Moline, Ottawa, Aurora, Danville, Kankakee, Blue Island, Chicago Heights, Oak Park and Waukegan.

EATING TOO MUCH

We eat too much, the doc insists; we're chewing things all day; we must reform, he wots and wists, or there'll be Hank to pay. Sometimes I read him as I run, he throws in me a scare, and I remark, "I'll have to shun the gorgeous bill of fare. I doubt me not the doc is right, his words are spiced with truth; and now, like some old anchorite, I'll live awhile, in sooth." I cut out all the juicy steaks, the rich imported cheese, I sidestep luscious pies and cakes and live on bran and peas. My waist I measure every morn to see if I have shrunk; and then I laugh the doc to scorn, and call his wisdom bunk. For I am bigger than I was, my girth is simply great; the sickly mashies, soups and slaws have added to my weight. And I am feeling like an owl that's moulted out of time; I lean against the fence and howl, and call the doc a crime. It may be dieting is good for those it doesn't harm; but I am done with shredded wood and hayseed from the farm. I'll eat good grub and if I die the coroner will find my system full of cake and pie, not hay and pumpkin rind.

WALT MASON.

HEALTH ALMANAC

One of the almanacs of the 16th century bore the following title:

"Pronostycacyon of Mayster John Thybault, medycyner and astronomer of the Emperyall Majestie, of the year of Our Lorde God MCCCCXXXIJ., comprehending the iij partes of this yere, and of the influence of the mone, of peas and warre, and of the sykenesses of this yere, with the constellacions of them that be under the vij planettes, and the revolucions of Kynges and princes, and of the eclipses and comets."

We are still prognosticating on the subjects of "peas and warre, and the revolucions of Kynges and princes," but the United States Public Health Service in its *Health Almanac for 1919* is not content with chronicling our various ills, but preaches prevention of the "sykenesses of this yere."

In addition to the monthly calendar of health hints and notable events, this almanac discusses such topics as the following:

Control and prevention of infectious diseases, as pneumonia, common colds, tuberculosis, infantile paralysis, typhoid fever, smallpox, trachoma, hookworm, disease, and venereal diseases.

Disposal of Human Excreta.

Importance of Clean Drinking Water.

Care of the Teeth.

Care of Milk in the Home.

What the U. S. Public Health Service is doing to protect the health of the people of the United States.

Copies of the 1919 almanac may be obtained free upon application to the U. S. Public Health Bureau, No. 3 B Street, S. E., Washington, D. C.

TOO GOOD TO PASS UP

A daughter of an Illinois physician has been spending a year in the Orient, and was on her way home via Australia.

One evening the captain of the ship was talking to the young lady, who lives not far from Chicago, and the conversation drifted to the physician. The captain, who had been having many passengers bound for Rochester, apologized for his lack of American geography, and said, "Say, where is this Chicago? Is it anywhere near Rochester?"

Correspondence

THE FREE VENEREAL CLINIC.

Editor JOURNAL:

It may seem rash to write or speak against anything our state or national authorities may see fit to do for us, but there are some things being done, and others proposed, the wisdom of which may well be questioned.

The "free social hygiene dispensaries" now being established in several places in this state appear to me to be extremely likely to cost far more than the benefits to be derived from them will warrant, and in the end tend to encourage rather than hinder the evils they are intended to correct.

"Free clinics" have generally tended to encourage pauperism. They can not be limited in their activities to those only who are really unable to pay for their treatment. They are robbing doctors of many thousands of dollars annually through this form of "charity." It is not to be denied that free dispensaries are helpful to the poor; and as we are to always have the poor with us they will probably continue to be necessary; but the "free venereal clinic" is one that is to be condemned. The reason is obvious. The man who acquires a venereal disease, often at great cost, can still raise a little money to pay for his treatment; or he has friends who will come to his relief.

In the rare cases where failure of health and poverty combine to render a man incapable of helping himself, some better method than the "free dispensary" can be devised.

If thousands of dollars are to be spent upon the class of men, and I say men advisedly (because there will be very few women who will avail themselves of the privileges of the free clinic), why not a "free tuberculosis clinic"? Tuberculosis is costing the state a great deal more, in both lives and money, than all the other contagious and infectious diseases combined. Do we see the authorities appropriating large sums to care for the tubercular poor? If the protection of the healthy is the motive for the "free venereal clinic," then why not do something to protect the healthy from tubercular infection?

But admitting the necessity for active supervision and treatment for the class who become infected by the venereal diseases; admitting that it is for the protection of the innocent; admitting that it does put back into productive occupations a few of the victims of their own indiscretions; admitting that these are entitled to more consideration than any other class of citizens, if this should be claimed by those in authority; does the plan commend itself as the best one? Is it the surest plan to get all venereal cases under proper treatment and under the necessary restrictions and control? Is it the least expensive?

From observations extending over a number of years, many of which have been given over to work among the very persons it is here sought to help, I am led to believe a much better plan would be to have every venereal patient treated by the doctor in each community who is best qualified for this class of service, and let him be paid by the state. The terms under which such treatment can be administered at the public expense being such as would assure that none but those entitled to free treatment could receive it.

This would obviate the necessity for the equipment of special laboratories and dispensaries. It would not rob the doctors. It would not add to the already overabundant free dispensaries.

This is not a "personal" plea. I do not treat this class of patients.

Effingham, Ill.
February, 24, 1919.

Dr. Don Deal,

Chairman of the Legislative Committee of the Illinois State Medical Society,
Springfield, Illinois.

Dear Doctor:

At the last meeting of the Effingham County Medical Society, February 11th, the members voted unanimously to oppose Mr. Shepardson's proposed Medical Practice Act and the secretary was instructed to inform you accordingly; also, that members of our society stand ready to give you, as chairman of your committee, all possible support, with their presence or otherwise, when this bill is called up for hearing. It is very unfortunate that the 1918 House of Delegates of the State Medical Society went off half cocked at last year's meeting and without any consideration whatever, endorsed Mr. Shepardson's legislative plan as applying to our profession. Mr. Shepardson unfortunately has said some very unfair things about the Medical Profession of Illinois—unfair in its application to the great big majority of the 10,000 doctors of this state. This would be true as well in its application to the rank and file of the medical profession of any other state. We do not attempt to deny that there are evils in our profession that should be corrected but I am thoroughly convinced, as no doubt you are, that the honest and legitimate majority of our 10,000

doctors are thoroughly opposed to this bill proposed by Mr. Shepardson, as well as to his attitude toward our profession as a whole.

This bill in a sense is vicious toward us, and it is not only our privilege but becomes our duty to fight down this element in his plans. Our profession has always been high minded and progressive and has a record for achievements along the paths of righteousness and justice and now as ever before are ready to co-operate in means to these ends; however, Mr. Shepardson's activities in the sense of this proposed medical practice act are proceeding in the wrong direction as regards our profession and the best interest of the public as well, as no community can rise above the level of its medical profession. It is hardly conceivable that Mr. Shepardson alone is right in this controversy and all of our 10,000 doctors in the state wrong.

I would suggest, doctor, that in your capacity as chairman of our legislative committee you feel free to exercise your right to demand that the doctors of the state lay aside their work when needed and respond to your summons to go to Springfield and to work unitedly under the direction of you and your committee when this or any other bill in which we are vitally interested is called up for hearing, and I would further suggest to the doctors of the state that each county society prearrange with a few of its members to go to Springfield and to take an active part in such hearings, when needed.

All of the doctors of the state should make known promptly their wishes in these matters to their legislators. A few years ago one of our most influential legislators who is still in the House remarked to me that they, the legislators, never knew what the doctors wanted nor how the majority of the profession viewed proposed legislation pertaining to it, for they remained indifferent, seldom ever going to Springfield to talk over these matters with their legislators and almost as seldom or never writing their views to them. It is a shame that out of 10,000 doctors in the state we probably never have a dozen of them in Springfield at any time to discuss with our legislators proposed acts of vital importance to ourselves and the public. It is our privilege and our duty to appear before the legislature in force when these matters come up for consideration, and our legislators would welcome such a

discussion and exchange of views in their effort to learn what course they should pursue in their capacity as law makers.

Let us all be ready to go to Springfield on short notice when this Medical Practice Act comes up for hearing, prepared to stay until it is defeated.

Very truly yours,

F. Buckmaster

Sec'y of the Eff. Co. Med. Soc'y

Society Proceedings

ADAMS COUNTY

The Adams County Medical Society met in regular monthly session on Monday, Feb. 10, at Elks' Club Rooms, Quincy, with a splendid attendance. After routine business was transacted the matter of annual registration of physicians was brought up and discussed.

Dr. H. P. Beirne, councillor for sixth district, told what had taken place at the meeting of the State Corncil in regard to the matter, and presented the resolutions adopted by that body at their meeting on Jan. 21, 1919. The same were read by the secretary in order to get the matter before the society. Dr. Ericson made a motion that the Adams County Medical Society go on record as being opposed to annual registration for physicians. Seconded. As an amendment to the above motion, Dr. Beirne offered the following:

"It is the sense of the society that we go on record as favoring a definition of the practice of medicine on the statutes of Illinois, as it is now and has been understood, interpreted and enforced by the War Department of the United States government during the present war."

Motion together with amendment carried unanimously.

A suggestion was made to have a good fellowship committee to adjust any petty or trivial differences which may arise between members in the local society. To be acted upon at next regular meeting.

Dr. H. M. Harrison read a most instructive, interesting and carefully prepared paper on "The Unwarranted Sacrifice of the Tonsil." The doctor received a rising vote of thanks for his paper, accompanied by much praise and many hopes for a similar one in the near future.

Dr. C. W. Hartford of Chicago, who was to have addressed the society on "Radium," was unable to attend on account of illness, but we hope to have him come in the near future. Adjourned.

ELIZABETH B. BALL, Secretary.

Quincy, Ill., Feb. 17, 1919.

To the Editor: The following action in regard to the annual registration of physicians was taken at the last regular meeting of the Adams County Medical Society, held Monday, February 10th.

It was moved by Dr. Ericson that the Adams County Medical Society go on record as being opposed to the annual registration for physicians. Seconded.

Amendment by Dr. Beirne, Councilor for the Sixth District: "It is the sense of this society that we go on record favoring a definition of the practice of medicine on the statutes of Illinois, as it is now and has been understood, interpreted and enforced by the War Department of the United States Government during the present war."

Motion, together with amendment, carried unanimously.

ELIZABETH B. BALL,

Secretary.

BOONE COUNTY

Belvidere, Ill., Feb. 6, 1919.

To the Editor: The Boone County Medical Society is very much opposed to the bill which is to be presented at this session of the legislature by the Department of Registration and Education of the State of Illinois, requiring physicians to renew annually their licenses to practice medicine.

We object to the unnecessary power given in this measure to this department, composed of civilians, permitting them to be yearly the judges of whom of the doctors they will allow to practice, and they to receive the complaints of dissatisfied people, jealous members of the profession, or unscrupulous people.

Many physicians have endured hardships and toiled years to gain a practice, and we believe this bill menaces our life's work.

Yours truly, R. W. McINNES,
President Boone Medical Society.

CHRISTIAN COUNTY

To the Editor: At a meeting of the Christian County Medical Society, held in Taylorville, February 20, 1919, the following officers were elected: President—Dr. T. A. Lawler, Taylorville.

Vice-President—Walter Burgess, Pana.

Secretary-Treasurer—Dr. D. D. Barr, Taylorville, Ill.

Delegate and alternate hold over from last year are G. L. Armstrong, Taylorville, and T. A. Lawler, Taylorville.

Legal Committee—J. N. Nelms, Taylorville.

Public Health—J. H. Mercer, Taylorville.

Censors—W. T. Short, Stonington; Geo. Tankersley, Owaneco, and G. C. Klein, Kincaid.

Dr. Wm. F. Hagar of Pana transferred his membership from Effingham Society to the Christian County Society.

The following resolution was unanimously passed:

Resolved, That this society emphatically endorse the action taken by the Council of the State Society and that of the Chicago Medical Society against the proposed registration act proposed by Mr. Shepardson, and that copies be sent to our representatives and senator and to Dr. Don Deal of Springfield.

The proposed legislation was heartily condemned by each member present and the opinion of all was that the measure was simply to give jobs to friends of the politicians and worse than of no use to the physicians.

The meeting adjourned to meet again at the regular time, the third Thursday in July.

D. D. BARR,

Secretary-Treasurer.

COOK COUNTY

CHICAGO MEDICAL SOCIETY

Regular Meeting, February 5, 1919

1. Pneumonia. A Comparative Study of Forty-Four Cases Among the Nurses at Camp Zachary Taylor, Kentucky.—George Rubin.

2. Studies in the Pneumonias and Other Acute Respiratory Infections at Camp Zachary Taylor, Kentucky.—Walter W. Hamburger.

Discussion, Solomon Strouse and George Weaver.

*A Joint Meeting of the Chicago Medical and the Chicago Pathological Societies,
February 12, 1919*

1. The National-International Relations of Sanitation in Ecuador.—Arthur I. Kendall.

2. Clinical and Pathological Manifestations of Yellow Fever (Lantern Slides).—Chas. A. Elliott.

Regular Meeting, February 26, 1919

1. Hypertrophic Periostitis with Decalcification of Skull Areas.—Cassius C. Rogers.

General discussion.

2. The Adhesive Plaster Method for the Rapid Regeneration of Skin Over Granulating Wounds. (Demonstration of Five Cases).—Emil Beck.

Discussion, Chas. E. Humiston.

Regular Meeting, February 26, 1919

1. Report of An Unusual Case of Anthrax.—Louis J. Pritzker.

General discussion.

2. The Skin, a Mirror to the System.—M. F. Engman, St. Louis, Mo.

Discussion, Rollin T. Woodyatt.

AUX PLAINES BRANCH CHICAGO MEDICAL SOCIETY

February 13, 1919.

To the Editor: At the regular meeting of the Aux Plaines Branch of the Chicago Medical Society, January 24, 1919, the subject of annual registration of physicians was discussed, and the society voted unanimously to oppose it.

Yours truly, MARY J. KEARSLEY,
Secretary Aux Plaines Branch.

KANKAKEE COUNTY

Kankakee, Feb. 17, 1919.

To the Editor: At the regular monthly meeting of the Kankakee County Medical Society, February 13, 1919, the question of annual registration of physicians was discussed at length. Mr. Francis W. Shepardson was present and presented his usual arguments in favor of this measure, but the Society took no action on it, pending the receipt of a copy of the proposed law, which Mr. Shepardson promised to send us as soon as it is ready.

Fraternally yours, J. T. Rooks,
Secretary.

MADISON COUNTY*Our January Meeting*

The first meeting of our society in the new year was held at the court house in Edwardsville, on January 3, 1919, with President John H. Siegel in the chair. Zero weather and rough roads greatly reduced the attendance. Members present: Schreifels, Siegel, Johnson, Harrison, Ferguson, Hirsch, Wahl, Range, Kaeser, Baumann and E. W. Fiegenbaum. Visitor, Mrs. E. S. Beatty.

The minutes of the last meeting (October) were read and approved. The following bills were presented: Against the Madison County Medical Society: Alton Floral Co., flowers, \$1.50; E. W. Fiegenbaum, stamps, telephone and ad. (3 months), \$14.88. Total, \$16.33. Against the Tuberculosis Association: Mrs. E. S. Beatty, salary as nurse, November, half-month, \$62.50; Mrs. E. S. Beatty, expense for same time, \$11.01; Mrs. E. S. Beatty, salary as nurse for December, \$125.00; Mrs. E. S. Beatty, expense December, \$9.56; Telegram Publishing Co., printing, \$3.00; Madison Republic, printing, \$4.50; E. W. Fiegenbaum, advertising (3 months), \$12.00; D. L. Glover, groceries, \$9.53; Harrison Tuberculosis Colony, care of Jesse Reed, \$15.00; Harrison Tuberculosis Colony, care of Clara Pracht, \$60.00; Harrison Tuberculosis Colony, care of Violet Bartlett, \$75; Harrison Tuberculosis Colony, care of George Mills, \$15.00. Total, \$405.85. All of above bills referred to Auditors Johnson, Hirsch and Ferguson, found correct and ordered paid.

Mrs. Beatty read her report for December, which was approved and placed on file.

The election of officers for the ensuing year resulted as follows: President, Chas. R. Kiser, Madison; vice-president, F. O. Johnson, Granite City; secretary, E. W. Fiegenbaum, Edwardsville; treasurer, J. A. Hirsch, Edwardsville; medico-legal member, E. F. Wahl, Edwardsville; censor, 3 years, E. C. Ferguson, Edwardsville; county tuberculosis director, M. W. Harrison, Collinsville.

Dr. E. C. Ferguson moved that the officers for the County Medical Society be declared the officers for the County Anti-Tuberculosis Association. Carried. The annual reports of the secretary and treasurer

were read by the secretary, referred to Auditors Johnson, Ferguson and Harrison, found correct and ordered placed on file.

Dr. Siegel, as retiring president, thanked the members for their hearty co-operation during the trying times of the past year and then inducted the new vice-president into the chair, as the newly elected president was absent. Dr. Johnson, with a few well chosen words accepted the gavel and entertained a motion to give a rising vote of thanks to our retiring president, Dr. Siegel, which was unanimously carried.

Captain Eugene F. Wahl, who has just returned from fifteen months' service in the army, gave a very interesting talk about his work at the cantonment, and about the conditions under which medical men rendered service. He spoke very highly of the medical and surgical care given to all cases at the base hospital, and also of the high character of the men associated with him in the work. A vote of thanks was tendered the speaker, after which the society adjourned to meet in Granite City on the first Friday in February.

Mrs. E. S. Beatty of Decatur, who for the past two or three months has devoted her time and energies in behalf of the tuberculosis work in our county, has sent in her resignation to take effect on the last day of January.

At our last meeting Dr. M. W. Harrison of Collinsville was elected County Tuberculosis Director. This is a new office, created last year, and carries with it the duty of leadership in all tuberculosis activities in the county.

Especial attention is to be given by the director to the returned tubercular soldiers from our county and to extend to them every assistance in our power. Professional care, practical advice and financial aid is to be extended wherever needed, and the health of the community safeguarded.

At a regular monthly meeting of the Madison County Medical Society the following resolutions were unanimously adopted:

WHEREAS, A paper advocating the annual registration of physicians was read by the director of the Department of Education and Registration before our society last August at the Alton State Hospital and received our endorsement before we had any opportunity to study the merits or demerits of the plan; and,

WHEREAS, A more mature study of all of its propositions disclosed many very objectionable features which might result detrimental to the best interests of our profession; be it hereby

Resolved, That we hereby rescind the action taken at our meeting last August and now most emphatically recall our endorsement; and be it further

Resolved, That we as a society express our most violent opposition to any form of annual registration of physicians, believing that the interests of the profession and the public can be fully protected by the prompt and efficient administration of the present Medical Practice Act.

Resolved, That a copy of these resolutions be sent to the chairman of our Medico-Legal Committee, to the director of the Department of Registration and Education, and our representatives in the legislature.

PEORIA CITY MEDICAL SOCIETY

February 6, 1919.

To the Editor: At the regular meeting of the Peoria City Medical Society, February 4, 1919, a motion was made by Dr. Albert Weil and seconded by Dr. A. J. Foerter that the society is unalterably opposed to any legislation which will require the annual registration of physicians, and that the secretary of the society inform each member of the legislature from this district of such action.

This motion was passed by a unanimous vote.

ROLAND LESTER GREEN,
President.

A. J. BLICKENSTAFF,
Secretary.

ST. CLAIR COUNTY

February Meeting

The St. Clair County Medical Society met in regular session at 8 p. m., February 6, 1919, with the following officers and members present: Walter Wilhelmj, president; C. W. Lillie, secretary; A. E. Hansing, treasurer, and J. W. Rendleman, C. E. Hill, J. C. Henry, Joseph Beykirch, C. A. W. Zimmermann, J. L. Wiggins, E. H. Lane, W. C. Spannagel, J. H. Fulgham, H. A. Cables, F. H. Gunn, C. L. Moeller, C. A. Winning, L. Green, E. W. Cannady, A. E. Rives and R. F. Stanton, members, and Drs. A. M. Rovin, Detroit, Martin H. Burge and J. Raymond Martin, St. Louis, guests of the society.

Minutes of annual meeting as printed in the Bulletin were approved.

Applications of Drs. J. Lippert, East St. Louis, and Louis Bauer, Belleville, were presented, approved by the Board of Censors, and on motion both were elected to membership.

Resolutions on the death of Dr. Adams were adopted, as follows:

The resolutions of the council of the Illinois State Medical Society regarding the proposed annual registration of physicians was read and was discussed by several members. Dr. J. L. Wiggins, representing the Department of Registration and Education, spoke at some length in favor of the plan, presenting every reason that could be offered in its favor, while Drs. Lillie, Lane, Fulgham,

Cables, Spannagel, Hill, Rendleman and Zimmermann opposed it. Discussion closed.

Dr. Zimmermann moved, Rendleman seconded, that the St. Clair County Medical Society instruct the Legislative Committee that this society is opposed to the proposed plan for the annual registration of physicians, and that this action be communicated to the senator and representatives from this county, and that they be urged to oppose it in the legislature. The motion prevailed, there being no negative votes.

Dr. Wiggins offered the following resolution, which was adopted:

"Resolved, That the members of the St. Clair County Medical Society extend thanks to our president, Dr. Walter Wilhelmj, and our secretary, Dr. C. W. Lillie, for their hearty co-operation and assistance accorded the Department of Registration and Education in its enforcement of the Medical Practice Act in our county, as this seems to be the only organized medical society in the state which has extended any aid to this department, and as the results have been so satisfactory the members of this society request a continuance of their assistance and counsel in aid of the department."

Dr. Wiggins offered other resolutions, but action thereon was postponed until our March meeting, at which time it is proposed to have the president of the State Society present, and at which a free discussion will be allowed.

Dr. A. M. Rovin, of Detroit, Mich., was now introduced and the society listened with approval to a very instructive discussion of "Modern Conceptions of Immunity." Discussion of the paper was opened by Dr. H. A. Cables, who voiced his approval of the position taken by the essayist. He was followed by Dr. C. A. W. Zimmermann, who presented some new thoughts in regard to "production of active immunity." Discussion was closed by Dr. Rovin, who contends that the facts already established regarding immunization justify a belief that much greater reliance can be placed upon the modern methods of gaining immunity than has heretofore prevailed.

By a rising vote the society expressed its appreciation of the paper of Dr. Rovin.

Society adjourned.

C. W. LILLIE,
Secretary.

Personals

Dr. E. M. Brewer has removed from Rantoul to Champaign.

Dr. and Mrs. P. L. Markley, Rockford, are touring California.

Dr. D. C. Roach, after military service, has resumed practice in Burlington.

Capt. H. O. Munson, after overseas service, has resumed practice in Rushville.

The office of Dr. F. H. Gardner in Moline was robbed of fifty instruments recently.

Dr. W. D. Chrisman, after service at Camp Grant, has resumed practice in Princeton.

Capt. W. A. Hinckle, after service at Camp Funston, has resumed practice in Peoria.

Dr. H. L. Fischer, after military service in Camp Sheridan, has resumed practice in Kewanee.

Dr. A. O. Owens, Princeton, has been elected president of the Bureau County Tuberculosis Association.

Capt. Leon Beilin, of Springfield, is said to be on the way to Siberia to fight an epidemic of typhus fever.

Dr. John F. Deal, after service at Spartansburg, S. C., has returned to Springfield and resumed practice.

Capt. Sumner M. Miller, after service in Camp Kearney and Camp Wadsworth, is said to have resumed practice in Peoria.

Dr. Samuel Sher, Chicago, found a burglar in his home with his plunder all tied up and battled him till the police arrived.

Robert B. Preble, Lieutenant-Colonel, M. C., U. S. Army, returned home, February 2, after seven months' service in France.

Norval H. Pierce and Channing W. Barrett, majors, M. C., U. S. Army, both of Chicago, returned from abroad, February 17.

Dr. John D. Colt, Litchfield, dean of physicians of Montgomery county, celebrated his eightieth birthday anniversary, January 12.

George C. Tallerday, Capt., M. C., U. S. Army, who has been with the American Army of Occupation in Coblenz, has returned from abroad.

Dr. William Allen Pusey, Chicago, has been appointed consultant to the division of public hygiene of the state department of public health.

Capt. James E. Woelfle, M. C., U. S. A., Cairo, Ill., on the Surgical Staff Base Hospital, Camp Dix, N. J., has received his discharge from the army.

Dr. John A. Wheeler, Springfield, has been en-

dorsed by the Sangamon County Medical Society as a candidate for commissioner of public health and safety.

Major Eli B. Moss, Chicago, is said to have been cited for bravery for rescuing wounded men under fire. He was wounded by shell fragments in the exploit.

Dr. Irvin S. Koll, after one year of service in the army, has resumed his practice in genito-urinary and skin diseases at 31 North State street, Chicago.

Dr. Rachele S. Yarros, chairman of the sub-council of the **women's committee** of the State Council of Defense, has been appointed supervisor of education for women.

Leo M. Beilin, Captain, M. C., U. S. Army, Springfield, started for Siberia, February 15, and is to be placed in charge of a unit to combat typhus in the United States base in Siberia.

John G. O'Malley, Capt., M. C., U. S. Army, has returned after more than three years service abroad, first with the Royal Army Medical Corps, and later in the Medical Corps, U. S. Army.

Lieut. John C. Murphy, after overseas duty with the medical corps of the 129th field artillery, has given up his practice in Davenport and is associated with his brother, Dr. W. L. Murphy, at Aurora.

Dr. Joseph C. Beck, who has been in charge of the Czecho-Slovak Hospital at Convak, France, has been transferred to Prague, Bohemia, where he is working in reconstructive and plastic surgery of the head and neck.

Harry D. Orr, Lieutenant-Colonel, M. C., U. S. Army, formerly surgeon of the First Cavalry, Ill. N. G., has recently been made division surgeon of the Thirty-Third Division, which is now on duty on the Rhine premises.

A. B. Middleton, Capt., M. C., Pontiac, Ill., who has had charge of the Base Hospital, Eye department, and served as the oculist of the Special Medical Board for the past year at Camp Travis, Texas, was discharged March 1st and returned to his home.

Dr. C. W. Hanford of Chicago gave a demonstration of the application of radium at St. Joseph's Hospital, Bloomington, to the members of the McLean County Medical Society. In the

afternoon he presented a paper on "The Later Phases of Radium Therapy."

Mr. Francis W. Shepardson, director of the Department of Registration and Education, has reappointed, as the medical examining committee for 1919, Drs. John A. Robison, William L. Noble and Guy M. Cushing, Chicago; Dr. Lewis C. Taylor, Springfield, and Dr. Jonathan L. Wiggins, East St. Louis.

News Notes

—It is announced that the state epileptic colony, Dixon, is to be enlarged with new buildings mostly of the cottage type, and that 700 patients from Lincoln and other state institutions are to be transferred to the colony.

—At the annual meeting of the Springfield Tuberculosis Association, February 11, Dr. Lewis C. Taylor was elected president, Dr. George Thomas Palmer, director, and Dr. Lewis C. Taylor and C. St. Clair Drake were elected members of the board of directors, and Dr. George F. Stericker, chairman of the executive committee.

—Someone connected with the Chicago Surgical Society made a bad break when he invited several prominent women physicians to attend a meeting of the society at the University Club. Dr. Cassius Rogers is said to have "burned up" the wires to secure permission to admit the ladies which was "agin the rules" of the club, but there was nothing doing.

—The Institute of Medicine of Chicago held a symposium on influenza, February 21, at the City Club. Papers were presented as follows: "Epidemiology," Prof. E. O. Jordan; "Bacteriology," Dr. David J. Davis; "Pathologic Anatomy," Dr. Edwin R. LeCount; "In Military Camps," Dr. Walter W. Hamburger; "Clinical," Dr. Solomon Strouse, and "Public Health," Dr. Heman Spalding.

—The Illinois Hospital Association has recently been organized, and the following officers have been elected: President, Dr. Malcolm L. Harris; vice-president, Dr. William L. Noble; secretary, Dr. Egil T. Olsen, and treasurer, Dr. Carl O. Young, all of Chicago. The purpose of the association is "to promote the welfare of the sick, to make a study of hospital problems and work out solutions to the best interests of the sick

and of the hospitals." The fair treatment of all hospitals in the standardization propaganda will also be taken up by the association.

Marriages

GUSTAVE GOODMAN HERPE to Miss Elsa Kuhn, both of Chicago, February 11.

JAMES WELCH GUEST, Chicago, to Miss Sarah Pickette Lindsey of Memphis, Tenn., Dec. 28, 1918.

Deaths

FRED G. KETCHUM, Springfield, Ill.; Hahnemann Medical College, Chicago, 1893; aged 54; died at his home, about January 9.

ALEXANDER CLAYTON JACOBS, Chicago; Marion-Sims Medical College, St. Louis, 1896; aged 44; died at his home, January 15, from influenza.

DAVID D. TALBOTT, Lewistown, Ill.; College of Physicians and Surgeons, Keokuk, Iowa, 1864; aged 81; was found dead in his office, January 18.

LUMAN L. WESCOTT, Chicago; Chicago Homeopathic Medical College, 1898; aged 52; died at his home, February 11, from arteriosclerosis.

JACOB LEONARD EISENDRATH, Chicago; University of Illinois, Chicago, 1904; aged 38; a Fellow A. M. A.; died at his home, January 25, from pneumonia.

PETER S. MACDONALD, Chicago; Rush Medical College, 1864; aged 82; associate of Dr. Daniel Brainard for two years and one of the oldest practitioners in Chicago; died January 20, from chronic nephritis.

JOHN ALEXANDER LYONS, Chicago; Long Island College Hospital, Brooklyn, 1889; aged 65; a Fellow A. M. A.; a member of the American Association of Obstetricians and Gynecologists; surgeon and gynecologist to the Chicago Hospital; died at his home, February 18, after an operation for appendicitis.

ANDREW ALOYSIUS CONLON, Chicago; Bellevue Hospital Medical College, 1885; aged 57; at one time a member of the Illinois State Medical Society; for nineteen years a member of the medical staff of the Chicago Department of Health; died at his home, February 19, from chronic parenchymatous nephritis.

CHARLES HUBART LOVEWELL, Chicago; University of Michigan, Ann Arbor, 1871; aged 70; a member of the Illinois State Medical Society; a pioneer practitioner of Englewood, where he located in 1875; for many years local surgeon of the Lake Shore and Rock Island systems; a member of the town of Lake school board from 1888 to 1890; died at his home, February 9, from cerebral hemorrhage.

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Original Articles

IS IT WORTH WHILE TO STUDY THE INSANITIES BY THE SCIENTIFIC METHOD?

ONE CENT FOR RESEARCH FOR EVERY DOLLAR
FOR CONFINEMENT.

BAYARD HOLMES, M. D.

The patients committed to our State Hospitals may be considered in two groups:

Group I. Patients upon whom a positive diagnosis is made by objective symptoms and findings, i. e., by a pathologic examination during life. This is the method used on all other non-mental diseases.

Group II. Patients obviously insane, but giving no objective symptoms or findings by the methods now practiced, sufficient to determine a positive pathologic diagnosis.

In group one are the cases of cerebral syphilis usually termed general paretics which make up less than twenty per cent. of the admissions or commitments, and much less than ten per cent. of the hospital population. They live less than three and a half years after commitment, and cost the State only \$700.00 each in direct custody. In group two are the dementia praecox patients who make up about twenty per cent. of the commitments, but because they live a long time in custody—more than fifteen years—they make up sixty per cent. of the population of the State Hospitals and they cost the State in custody alone more than \$3,000.00 each. More than fifty per cent. of this group die of tuberculosis, and seventy-five per cent. show active tuberculosis at autopsy.

Because this group termed dementia praecox make up more than half the total insane population and for the sake of simplicity we will consider this group alone in the following plea for

research in causes, and possible cure and prevention.

The term dementia praecox is at once allowed to be an inclusive clinical diagnostic name. It is symptomatic. The autopsy shows no characteristic pathologic lesions. There is no pathologist in the world who could tell at autopsy which of two cadavers was that of a genius or which was a dementia praecox patient. Yet clinically the diagnosis is easy after the disease has progressed for some months or years.

The clinical method was adequate in the past to make the diagnosis of syphilis, the wound diseases, diphtheria, cholera, typhoid fever, typhus fever, small-pox, anthrax, malaria, the sleeping sickness, kala azar, yellow fever, the plague, beri beri, rheumatism, trench fever, elephantiasis and many less known conditions, and later the pathologists determined the post-mortem findings and thus established a method by which one could determine by the cadaver alone what had been the cause of death. The third step was taken when research determined the causes of these diseases and the methods of cure or prevention. We have taken only the first step in recognizing a clinical group of the youthful insane which we now term dementia praecox patients.

Allow now one presumption in regard to this group, namely that these patients suffer of a natural (as opposed to a supernatural) ailment, or of a tangible (as opposed to a mystical) complaint. In other words these patients are like those who suffered of the diseases above mentioned, which have been more or less completely subjected by scientific investigation, and either cure, prevention or immunity has been attained.

Small-pox was conquered by one man but he did not discover the ultimate cause of the disease and in the hundred twenty years since he gave protection to the world and life to one four-

teenth the children born, no one has been able to discover the cause of small-pox.

The cause of syphilis is known and a means of prevention and cure is established.

A hundred years after typhoid fever was recognized clinically and at autopsy, that disease is completely conquered. Immunity is established by a simple method, one safe and painless.

So of each of the others had we time and space.

No disease has been able to hold out against the assaults of science. Some have been discovered by solitary medical scouts; others, like yellow fever, only by mass investment—by sapping and mining.

By the application of the same scientific methods that have led to the conquest of the above mentioned diseases dementia praecox is sure to yield.

Francis Bacon said long ago, "It would be madness and futile to presume that things which have never yet been accomplished can be accomplished without employing some hitherto untried means." The dementia praecox problem has never yet been besieged by an adequate group of investigators. The U. S. Army Medical Corps solved the yellow fever problem in a single season of investment and put in the administrative junk pile the whole expensive quarantine service which had annually cost the general government and the Southern States millions in treasure and life. It reduced the building of the Panama Canal to an engineering problem uncomplicated by a mysterious and death dealing pandemic which rendered the French company bankrupt.

Dementia praecox will not be conquered and half our insane asylums closed up for want of patients unless some hitherto untried means are used to solve this problem. Horatio M. Polloch, the Statistician of the State of New York, advised his Commission that in his opinion it would be good economy as well as true humanity to expend \$100,000.00 a year in seeking for the causes, the possibilities of cure and prevention of dementia praecox, which now brings 1500 youths into the hopeless custody of the State and imposes a direct and indirect expense of more than \$10,000,000 a year on the State. During one year 21,070 dementia praecox patients were under care in New York and 21 were discharged recovered while 852 died!

I predict, with good reason and after reading carefully and critically the history of research during the past, that adequately supported research into the causes, the possibilities of cure and prevention of dementia praecox will not only be rewarded with success in less than a decade, but that unlooked for discoveries will be incidentally made which will give a clew to methods of mental acceleration and activation which are now inconceivable except to quacks.¹

The Royal Institution was established in London in 1799 "for the purpose of alleviating the conditions of the poor." The additions which that Laboratory of Research made to human knowledge during the following 100 years have multiplied the horse-power available to man more than the discovery of a continent would have done. That Institution was organized by Benjamin Thompson, the exiled schoolmaster of Concord, New Hampshire, the most practical advocate of research and military efficiency.

Every delay in beginning this research into the causes of dementia praecox is a delay in accomplishing its object.

If yellow fever had not been conquered in 1900 the canal would not be open today. If research for the cause, cure and prevention of dementia is not begun at this time, 40,000 American youths of high school and college age will go into our mad houses (never to come out alive) before the next legislature can provide for it, and the happy homes of Illinois will furnish their quota for this draft of twenty regiments a year.

There can be no doubt that well equipped research can expeditiously solve the problem of dementia praecox. Twenty young men well equipped in as many fields of scientific endeavor studying half a dozen patients synchronously in their several fields for a sufficient time will surely cause the fortress of our ignorance of dementia praecox to fall. Thus would 20,000 youths each year be saved to home, country and happiness.

¹An old and discarded maxim. "Nature abhors a vacuum," may be perhaps responsible for the trend of thought, if not of reason, which gives vogue to many pseudo-sciences and quasi-sciences. Note in this connection *The Philosopher's Stone*, Atlantic Monthly, April, 1918, and F. Matthias Alexander, *Man's Supreme Inheritance*, 1918.

Haddock, Frank Channing, *The Power of Will*, a practical companion-book for unfoldment of selfhood, etc., etc., 1909.

Haddock, Frank Channing, *The Culture of Courage*, a practical companion-book for unfoldment of fearless personality through the white life of reason and harmony, etc., etc., 1910.

Haddock, Frank Channing, *Business Power*, a practical manual of financial ability, etc., etc., 1910.

A writer in the *Edinburgh Review* for 1911 says:

It is an interesting question as to how far the solution of a vexed problem is facilitated by the preliminary study of previous attempts to solve it. Most people, if asked offhand, would regard it as an axiom that the history of opinion on the subject they are studying must be of some value in advancing that study. Yet, in many of the problems of science, we are inclined to believe that correct solutions are more likely to be achieved by a mind coming fresh from the prevailing intellectual atmosphere of modern times than by one that is steeped in the heterogeneous mixture of truth and of falsity which emanated from a less scientific era. We would not, of course, suggest that historical studies are devoid of interest or value—far from it; but we would suggest that the most profitable attitude with which to approach them is rather that of the archaeologist, whose opinion on modern problems is really formed, and whose interest in the past is purely abstract and impersonal, than that of the scientist who looks for new light on old questions. A chorus of dissent will no doubt greet this heretical proposition, yet we think it can be supported on sound psychological grounds. We might urge, if we like, that the history of opinion—being mainly a history of errors—would generally be unremunerative investment of time to search over the masses of chaff for the few grains of wheat they may contain; but this is not our line of argument. We mean something more positive than this. We mean that a mind encumbered with pre-existing theories of a subject is to that extent incapacitated from entertaining any theory that is new or out of relation to what has gone before. A mind that comes direct from a study of the past is likely to reach solutions of problems not widely different from the solutions of the past. But a mind whose only preparation is derived from immersion in the discipline of the scientific atmosphere of the time is more likely to arrive at a solution on novel lines.

The only research laboratories established in the United States have failed less because of inadequate financial support than because of scepticism of the laboratory staff selected from the traditional keepers of the insane. There has never been an independent laboratory for psychiatry. It has always been hitched on to service and custody. The Board of Lunacy, or other Trusteeship of the State, has been made up of a distinguished and successful institutional man, a psychiatrist, and a majority of business men and professional politicians. These men have been devoted to efficiency in equipment in housing, in labor economics, in keeping down the *per capita* expenses and in establishing such methods and details as they have learned in the manage-

ment of big business. These men are naturally ignorant of the history of research and wholly incompetent of themselves to appreciate the possibilities of investigation to solve the problems of the insane. In Massachusetts the earnest researchers at Danvers are on a small scale and overshadowed by custody and service. At the Boston State Psychopathic Hospital the department of the custody, social service and hospital service for the acute insane and for the mentally disturbed and distracted voluntary patients, as well as service work and education, distract and disturb the research work. Nevertheless, their researches in morphology, in diagnosis, in treatment and in chemical study of the blood and spinal fluid are the most important presented by any State Service. The work of the Psychiatric Institute of New York is largely service, but also educational. Most of the researches are stolen time from daily routine. The morphologic studies still continue and the work on the inorganic constituents of the brain is slowly approaching an available mass and form. Elsewhere a pathologist, or a pathologist and a chemist, largely devoted to ward and routine duties, administer the laboratory equipment in the Central State hospitals. They do as much work as can be expected under such conditions. The hypocritical acknowledgment of the need of laboratories is the first step toward righteousness and realization.

The President of the Carnegie Institution has naturally had much experience in the problems of research and the conditions under which the most successful researches could be expected. In his Report of the President for 1914, Robert S. Woodward comments on the extent of the Institution's experience during fifteen years, and sums up in a few paragraphs the conditions favorable to successful research, as follows:

1. It is inimical to progress to look upon research as akin to occultism, and especially inimical to mistake able investigators for abnormal men. Successful research requires neither any peculiar conformity nor any peculiar deformity of mind. It requires, rather, peculiar normality and unusual patience and industry.

2. Fruitful research entails, in general, prolonged and arduous if not exhausting labor, for which *all the investigator's time is none too much*. Little productive work in this line may be expected from those who are absorbingly preoccupied with other affairs. Herein, as in other vocations, it is difficult to serve two or more exacting masters.

3. Those most likely to produce important results in research are those who have already proved capacity for effectiveness therein, and who are at the same time able to devote the bulk of their energies thereto. In general, men are not qualified for the responsibilities of research until they have completed independently and published several worthy investigations.

4. Research, like architecture and engineering, is increasingly effective in proportion as it is carefully planned and executed in accordance with definite program. A characteristic defect of a large majority of the proposals for research submitted to the Carnegie Institution is a lack of tangible specifications. Estimates—especially of time and funds essential to carry out such proposals—are almost always too small. Those commonly made, even by skilled investigators, may on the average safely be doubled.

5. In spite of the most painstaking foresight, research tends to expand more rapidly and hence to demand more rapid increase of resources than most other realms of endeavor. Its unexpected developments are often more important than its anticipated results, and new lines of inquiry often become more urgent than those carefully prearranged for pursuit.

6. It is much easier in general to do effective work of research in the older fields of inquiry than in the newer ones. It is especially difficult to enter those fields in which there is as yet no consensus of opinion concerning what may be investigated and what criteria may be followed.²

In succeeding reports Woodward refers to the growing interest and faith which the unreflecting public manifests in the need and efficiency of scientific research. He attributes this public opinion in a large measure to the work and research methods of the Departments of Agriculture and Annual Industry. He refers to the growing tendency of large manufacturing industries to maintain Research Laboratories of special Industrial Research. This leads him to another series of conclusions: (Report of the President, 1915.)

1. "Sound research, like any trustworthy work, is expensive in proportion to its comprehensiveness and thoroughness.

2. "The number of projects worthy of investigation is now far greater than can be adequately financed, and hence advantageously pursued, either by any single agency, or by all such combined; and the prevalent lack of financial support for this kind of work appears destined to continue indefinitely, certainly so long as there is no general recognition of existing conditions or of practicable ways of improving them.

3. "Therefore each research organization must choose for itself at any epoch the field or the fields it will cultivate, and must restrict itself to them."

Probably the one question which consciously or unconsciously dominates the mind of every Administrator of Institutions for the Insane and every legislator when he is called upon to appropriate one-third of the total State budget for the hopeless custody of these wards of the State is really this: "Is there no way of stopping this terrible expense and waste of human life and happiness?" The answer to this question is one which comes from the history of research into the causes of other diseases. "It will be stopped and the institutions for the insane will be emptied when the causes and the methods of cure and prevention of the insanities have been discovered by adequate research."

The President of the Carnegie Institution makes definite audit of the probabilities of return from investments in research. He says:

"While there is inherently an element of uncertainty in respect to the comparability of returns with outlay in the conduct of research, this uncertainty is in general much less than in most unexplored fields for investment of effort and capital. Systematic research is quite certain to secure some advance. . . . The cost of progress attributable to deliberate investigation have been and still are vanishingly small in comparison with the costs of less contemplative forms of human endeavor."

Woodward makes his position on the need of a complete devotion of all the interests of the research institution to the work in hand, untrammelled by any extraneous obligation. He says that when the Institution was first established it was the general opinion of the officers that a large amount of valuable work could be accomplished under academic guidance by needy students who might thus earn from the Institution small stipends while doing the drudgery and acquiring the inspiration of research. But these plausible theories have failed to meet the requirements and conditions as they actually developed. From the students from whom so much for so little was expected it turned out that they were preoccupied as a rule with the elementary notion that research means that modicum of investigation which leads to higher academic de-

²These quotations are abbreviated, but essentially direct.

grees. Research is exacting, and not an episode in an organization or in an individual. It must be a continuous pursuit—not a transient adventure. While ends are accomplished and demonstrations are made the field of research broadens and the need of research increases. One thing alone may be asserted with confidence, and that is that the methods of science which have proved effective and trustworthy in the past in solving the problems of disease will prove still more effective and trustworthy in solving the problems of the insanities in time to come.

"If investigations cannot be well done they are of little worth; if nothing can be proven, they are of still less worth, or at least only of negative value. It has not infrequently been

(Continued on page 200)

HYPERTROPHIC PERIOSTITIS WITH SUBSEQUENT DECALCIFICATION OF SKULL AREAS.*

CASSIUS C. ROGERS, A. M., M. D., F. A. C. S.
CHICAGO.

Mr. President, Members Chicago Medical Society: I wish to present a case that has been of interest to me. *History* Father living aged sixty-three and well. Mother living, aged fifty-seven and well. Two brothers living and well, ages twenty-nine and nineteen, respectively. No brothers or sisters dead.

Personal History: Female, aged twenty-three, American, single. Menstruated first at the age of fourteen, regular and not painful. She has had the usual diseases of childhood and complained of rheumatism at intervals during the years 1910, '11 and '12, or from the age of fifteen to seventeen.

In the early part of February, 1912, she began suffering with pain back of the right ear, also severe headache. After doctoring for two weeks the pain left and she was free from pain for six weeks, when it again started in the form of intense headaches located in the right temporal region. Soon after this she noticed her eyesight was not good. She was treated for the impairment of vision at once, but in spite of all treatment after twenty months of suffering she lost the sight of both eyes to the extent that she could

only recognize light from darkness. All this time she had continuous cold and severe headaches.

On November 19, 1913, or twenty-one months after the onset of her trouble she had her tonsils and adenoids removed, and in about a month the sight began to return in both eyes, the headaches having disappeared almost immediately after having her tonsils removed.

By April, 1914, or twenty-seven months after the onset, her eyesight was again very good. One month later, or May, 1914, a sharp pain started again in the right mastoid region. This continued to grow worse. Soon after this she lost her appetite and could not sleep. The pain remained localized in the right mastoid region until September 1914, or two years seven months from the onset, or four months after its second return. At this time she noticed a pain in the back of her head in the median line just above the occipital protuberance. Shortly afterward a swelling about the size of a hen's egg developed in this region. She had been taken to a hospital in August, 1917, for treatment and there she was given potassium iodid internally, and inunctions of mercury together with injections of mixed vaccines. This treatment was continued from August to November, 1914, three months, when she was operated upon in the region of the swelling. There is no history of free pus being found, but the report is there was a necrosis of the outer plate of the skull.

On December 5, 1914, two years ago ten months after first onset and one month after previous operation, the pain developed in the region of the left mastoid, with all the characteristic symptoms and signs of an acute mastoiditis.

On January 5, 1915, or one month after this acute onset, the left mastoid was operated upon, there was no free pus and the wound healed in five weeks. The pain, however, did not subside.

February 18, 1915, six weeks after the first operation, the left mastoid was operated on the second time and there was a copious discharge of pus for two months, after which the wound gradually healed.

March 15, 1915, three years 1 month after original onset, the pain developed for a third time in the right mastoid region. This continued until July 6, 1915, or for four months. During this time the pain was so severe that she would

*Read before the Chicago Medical Society, Feb. 26, 1919.

become unconscious at times and she was given large doses of morphin to enable her to get rest.

On July 6, 1915, the right mastoid was operated upon and diseased bone removed, also three enlarged cervical glands. There is no history of free pus being found on this occasion.

September 20, 1915, or ten weeks later, the pain returned in the region of both mastoids and over the entire left side of the head.

October 19, 1915, or three years and eight months after the onset of the pain in the right mastoid, or eleven months after the first operation, she came to the University Hospital, where I first saw her. After obtaining the previous history and securing the following blood findings—hemoglobin 80 per cent.; reds 4,744,000; leukocytes 8,000; neutrophils 59.4; small lymphocytes 17.2; large lymphocytes 13; eosinophils 2.1; transitionals 8.2—we found that external pressure increased the pain in the region of both mastoids.

The following morning, October 20, I operated upon both mastoids, removing necrosed bone from both sides with considerable granulation tissue. No free pus. I found the roof of both mastoid antrums necrosed so that the dura, or periosteal layer of the dura, was exposed. A plate of skull was removed above the mastoid regions, so the periosteum could be readily exposed to view. It was found covered with granulation tissue. Free drainage was established. The patient remained in the hospital for sixteen days and was discharged with both areas healed. She returned to her home in Detroit but again returned to me on January 4, 1916, or two months and a half after I first operated on her. At this time I found the left ear greatly swollen and drained a subperichondrial abscess. This was slow in healing, as it was eleven weeks before it was entirely well. Unfortunately, a culture was not secured.

On June 23, 1916, or eight months after my first operation, the pain returned in the region of the occipital sear; also on the vertex of the skull in the median line.

October 7, 1916, one year after my first operation, she returned to the University Hospital; the old sear was removed, but this had no effect upon the pain.

December 13, 1916, I again operated upon her,

this time removing a plate of skull two inches in diameter in the region of the old occipital sear, and another plate of skull in the region of the pain at the vertex. In these areas the skull was found to be soft and spongy and it cut a great deal like rubber. It would bend but not break. The periosteum was covered with granulation tissue, but no free pus was present. Cultures from this granulation tissue proved negative. She remained in the hospital eighteen days and left free from pain, but on January 21, 1917, or two months and a half later, the pain returned, well localized at the left parietal region.

March 22, 1917, she returned to the University Hospital and without delay we removed a plate of skull from the painful area and found it similar to the ones that had previously been removed and the periosteum had the same granulated appearance. The pain disappeared at once and she left the hospital on the eleventh day. This relief from pain, however, was not permanent.

On May 26, 1917, she informed me that the localized headaches had reappeared. June 6, 1917, I removed another area of diseased skull. Still another area had developed by August and this was removed, and again another on October 11, 1917, or two years after my first operation; 5 years and eight months from original onset. The piece of bone removed each time was soft and pliable; in other words, decalcified. At no time did culture reveal any infection in these areas. The pain was always of the same gnawing, boring character, and grew steadily worse, and was relieved by each operation only to return in another locality. During this time she had had four operations in Detroit and six by me. R & L mastoid dura exposed on both sides and six plates of skull removed; in all 23.3 square inches. The pain was worse about midnight, and would remain intense until 4 or 5 o'clock in the morning, when it would gradually become easier. Drugs were, however, usually given.

During this period of her disease she had had four blood Wassermann's, three in Detroit and one in Chicago, made by reliable parties, which were all negative. A spinal fluid Wassermann was made by Dr. Orndoff which was also negative. There was no reaction from the tuberculin test. Blood culture proved negative. Suspecting a specific periostitis and osteomye-

litis, I gave her potassium iodid until I got the physiological reaction, which was only fifteen grains three times a day.

On October 19, 1917, she was transferred to the Frances Willard Hospital, and was under the care of Dr. B. H. Orndoff for nine weeks, the treatment he advised being directed to increase bony metabolism. The rationale of the plan was based upon data derived from experimental work in the control of bony metabolism by interference with the secretions of the ductless glands, particularly the thyroid and parathyroids, as recorded by McCallum. In brief, it consisted of the hypodermic administration of therapeutic doses of pituitrin, epinephrin, thyroprotein and corpora lutea alternately. These injections were given every day for fifty-four days, when she went home and was free from pain but in August, 1918, at our request, she returned for further treatment. This time she was given twelve injections, one every second day, and up to the present time has had no headaches since she started the serum treatment, which was one year and four months ago.

Dosage of serum:

Pituitrin	0.3 C.C.
Epinephrin	(1-1000) 0.2 C.C.
Thyroprotein	(P. D. & Co.) 1-50 gr.
Corpora Lutea	(Sol. Est.) 0.5 C.C.

Conclusions

This patient undoubtedly had originally a low grade infection in the right mastoid of perhaps sclerosis which necrosed or decalcified the roof of the mastoid antrum, producing a subperiosteal abscess or irritation in the middle fossa of the skull. The outer dura or periosteum being the most sensitive structure in the cranial cavity, the slightest irritation produces a maximum degree of pain. The dura is a non-elastic membrane lining the entire cranial cavity, so that we have the following conditions in subperiosteal irritation or abscesses: A non-elastic tissue on one side and the rigid skull on the other. As the normal contents of the skull cavity is sufficient to just fill it, the slightest increase of pressure produces symptoms which are as follows: Pain, dizziness, cerebral vomiting, subnormal temperature slow pulse, with an increased blood pressure, slow respirations and slow cerebration.

Depending in severity upon the amount of pressure and susceptibility of the patient to pain. Pupil findings are of no value. As the pressure increases the symptoms become more pronounced and the patient may become comatose, and unless the intracranial pressure is relieved the case may have a fatal termination. The condition may become chronic, as in this case, and the vision may become temporarily impaired and return to normal after the intracranial pressure is relieved. If the intracranial pressure is not relieved optic atrophy may develop and permanent blindness result. On account of the irreparable damage done in continued intracranial pressure these cases should be recognized early and promptly relieved, and this should be done by removing a plate of the skull. In these cases where the intracranial pressure is due to extradural or subperiosteal conditions, it is not necessary to open the dura to relieve the pressure.

It should however, be remembered that the optic nerve is not affected in all cases of intracranial pressure. The ophthalmoscopic examination should be made in all cases of suspected intracranial pressure, and the proper value placed upon the findings. Finding the nerve normal, however, does not mean that there is no intracranial pressure, as great pressure sometimes is found with normal disc.

Spinal Puncture: In cases of increased intracranial pressure if the cerebrospinal fluid is able to circulate freely from the cranial cavity into the spinal cord the spinal puncture will be of diagnostic value in determining the amount of intracranial pressure. The amount of intracranial pressure cannot be determined by the rapidity of the flow from the needle, for the fluid in the cord may be readily discharged through the needle and the flow become very slow, while the intracranial pressure is not relieved in the least on account of the blocking of the circulation of the cerebrospinal fluid at the foramen magnum, or some other point. It is only by the use of the water manometer that the intracranial pressure can be accurately determined.

In subperiosteal abscesses producing intracranial pressure spinal puncture may be of great harm, for the reason that the intradural pressure and

the extradural pressure is equal, but as soon as the intradural pressure is relieved, or lessened, the intradural and extradural pressure has a tendency to equalize and this is done by enlarging the cavity of the extradural abscess by stripping the dura or periosteum from the skull, sufficiently to equalize the internal and external pressure. By this means the abscess cavity is enlarged, the intracranial pressure is soon as great as it was originally. The result is that the brain becomes more and more anemic as the extradural abscess increases, and repeated spinal punctures may produce a disastrous termination.

The stereo roentgenogram is of inestimable value in all cases of mastoiditis, necrosis of the skull and the extradural lesions. The flat X-ray plate tells us little.

The serological localization tests of Abderhalden are of value in determining whether there is an actual brain lesion or simply an irritation of the dura. An early diagnosis of extradural lesions, especially abscesses, should be made if we expect to protect our patients from the invasion of the infection to other parts. The irritation of the dura has symptoms so pronounced and characteristic that they should be recognized at once when the irritation is due to infection extending from any of the accessory sinuses.

The case I have presented tonight and the results obtained thus far from injections and the administration of the internal secretions would lead me to believe it is one of disturbed bony metabolism, for until this treatment was given there was no arrest in the progress of the disease.

25 East Washington Street.

CHICAGO, ILL., February 18, 1919.

I examined Miss R's eyes and find no signs of optic neuritis nor optic atrophy. Her vision in the right eye is 20/60 and in the left 20/200. +250 () +125. Axis 90, improves vision of right eye to 20/50. +350 () +125 C Axis, 60, improves the vision of the left eye to 20/100. I am of the opinion that the left eye is a congenital amblyopic eye.

R. H. GOON, M. D.

IMPERFORATIONS OF THE RECTUM AND ANUS AND THEIR TREATMENT.*

J. RAWSON PENNINGTON, M. D.

CHICAGO.

Malformations of the rectum are rather common. I have collected forty-nine examples in a total of 292,810 newborn, which gives about one in every 5,900 births. There is a great difference in the experience of individual observers. For example, Moreau, after a service of forty years in maternity hospitals, had come across but four cases. Anders, who reported twenty-one cases, stated they occurred among about 230,000 treated at the Elizabeth Children's Hospital (Petrograd) in fifteen years.

On the other hand, Giraldes tells us that in eight years, twenty-six cases of imperforate anus were treated at the Children's Hospital (Paris), and he himself operated on six within a decade.

Judging by 639 examples of various malformations, I succeeded in gathering from thirty-seven authors, the sexes are about equally liable—347 males and 292 females.

Such malformations can be divided into three classes: 1, the rectum communicating abnormally with the bladder, urethra, vagina, etc., due to persistence of the original opening into the cloaca. 2, non- or imperfect development of the post-allantoic gut; and 3, non- or imperfect development of the proctodeum. Or a combination of two or more of these. It is excessively difficult to get any idea as to the frequency of the different types, but after a tedious search, I have tabulated 493 cases, and it is very interesting to note that these three classes are represented almost equally—167, 145, and 181 cases respectively.

Class 1 is beyond the scope of this paper, but before discussing Nos. 2 and 3 I will recall some points in the embryology:

The importance of the ingestion and assimilation of food for the future well-being of the individual is shown by the early stage of development at which the digestive tract commences to be built up. The primitive intestine consists of a groove, but soon becomes a straight tube of mesoderm lined by entoderm. This tube ends blindly in front and behind, and consists of the foregut in the head fold, the midgut in the body proper, opening widely into the yolk sac, and

*Read before the Illinois State Medical Society, at Springfield, May 22, 1918.

the hindgut situated in the tailfold. Here again we are concerned only with the hindgut.

At first the dilated posterior end of the hindgut communicates with the allantois, and has emptying into it the ducts of the primitive urinary and sexual organs. It thus forms a cloaca which persists through life in some of the lower animals, such as the Australian duckbill. In human beings, however, a cloaca merely persists till the time when the downgrowth of a septum (the future perineum) divides it into a larger anterior (or urogenital) and a smaller posterior (or rectal) recess. The latter is still imperforate.

The anus is formed by an invagination—the proctodeum—shut off by the anal membrane from the cavity of the rectum. First located in the dorsal surface, with the curving of the body axis as the embryo develops, the anal membrane is forced round the posterior end to the ventral surface. By the breaking down of this membranous septum, the communication between the rectum and anus is established.

Since the proctodeum is not at the extreme hinder end of the intestinal tract, but a little in front, there is left a post-anal gut, which normally disappears about the fourth week.

In malformations, the orderly course of development has been disturbed. Haeckel (of Jena), whose utterances since the beginning of the world war, have disgusted his former admirers, long ago pointed out that the development of the individual (embryogeny) is a short recapitulation of the development of the race (phylogeny).

Wood-Jones states that in the early human embryo, the rectum opens into the upper cloaca near the ending of the genital ducts. From this primitive opening, the rectum descends both in embryogeny and phylogeny until it finally opens at the anus. He looks on the portion from the primordial opening to the new one on the external surface, as a post-allantoic prolongation from the primitive rectum to bridge over the gap from the hindgut to the proctodeum. Hence, opening of the rectum into the male urethra, for example, would be an instance of reversion to a primitive type, imperforate rectum, to non-development of the post-allantoic gut, and so on.

So far so good, but we are still in the dark just why, in some instances, development proceeds normally, while in others the post-allantoic gut

does not develop and there is imperforate rectum as a consequence; or the anal membrane persists and we have imperforate anus, etc. It seems remarkable that 292,761 babies should be born without malformation, while forty-nine come into the world with various degrees of maldevelopment of the rectum or anus, or both.

Whatever the cause, it operates in animals as well; for atresia ani is found in the domestic animals, though more common in dogs and pigs than in horses or oxen. Moreover, several examples are known of hereditary transmission and of occurrence in twins.

I now proceed to describe Classes 2 and 3 more at length:

Non- or imperfect development of the post-allantoic gut. This class is further subdivided into two types. In the first, the rectum ends blindly; and may or may not be attached to the skin by a fibrous cord, possibly containing some unstriped muscular tissue. The rectum alone may be lacking, or the sigmoid as well with more or less of the colon. In some instances, the anal depression is present, in others absent. The second type is practically the same, except that the bowel is not attached to the male or female sexual organs. It may miss connection with the anal depression and extend down on one side, carrying the peritoneal cul-de-sac with it. This type also may be provided with a fibrous cord.

Class 3, which embraces *non- or imperfect development of the proctodeum* is also subdivided into two types. In the first of these, while the rectum and proctodeum are present and well formed, they are divided by a persistent anal membrane. Normally the anal plug breaks down about the beginning of the third month of fetal development, leaving the ano-rectal passage free. However, the membrane may be invaded by tissue from the mesoderm, and being thus thickened, persists with imperforate anus as a consequence. In the second type, the proctodeum is either partly or wholly undeveloped. As a result of operative experience it has been known for many years that the degree of development of the proctodeum affords no clue as to the state of the rectum itself. Thus of seven specimens of anus vulvalis examined by Keith, the proctodeum was absent in every one. In ten other females, where the rectum ended at or near the perineum, an anal depression was present in all; in ten others, in which the rectum ended blindly at or above

the vagina, the proctodeum was absent in two, partly developed in one, and well developed in seven. In males, with the rectum opening into the urethra there were seven specimens with the proctodeum well marked, and three where it was partly developed. In seven instances, where the rectum ended blindly at or above the prostate, the proctodeum was absent in three and present in four; when the rectum nearly reached the perineum the proctodeum was well marked in all.

In some excessively rare cases the post-anal gut instead of disappearing, remains patent and feces escape externally in addition to the anus.

Another variety, not very common, is where bands run across the anus either antero-posteriorly or from side to side. Of course, here the obstruction is not complete. The reason for this is obscure.

These imperforations are usually discovered at birth or at least within a few hours, though sometimes an amazing length of time elapses before they are discovered. Where the bowel ends in the bladder, the discolored urine and the absence of meconium on the napkin soon attract attention, or should do so. In openings into the urethra, meconium is passed independent of urination.

If the communication is with the vulva or vagina, years may elapse without anything wrong being suspected. Delbet quotes a remarkable case from LeFort, in which the patient herself, her husband and the physicians who delivered her on three occasions were unaware of the existence of a vaginal anus. It was finally discovered at the age of forty-eight by another physician making a digital examination of the rectum.

Fecal vomiting is not very common, and appears late. When not relieved, the abdomen becomes immensely distended; in one case it was 21 in. in circumference; in another, the bowels moved almost continuously for twelve hours after operation.

There is considerable difficulty sometimes in diagnosing the condition, especially where the proctodeum is absent and one is unable to tell just where the blind end is. Inserting a catheter into the bladder or vagina is uncertain; sometimes extremely so. Narrowing of the pelvic outlet, the ischia closer together than normal, with atrophy of the sacrum and coccyx often accompany absence of the rectum, though this, too, fails from time to time. When the blind end of the

rectum is low down, an impulse may be communicated to the examining finger by the child coughing or crying, or when the abdomen is pressed on.

Cases with complete obstruction are, of course, ultimately fatal, unless operated on, though death has been occasionally delayed for a long time; on one occasion over three months. The imperforate anal membrane has occasionally burst from pressure of the pent-up feces, but this should not be expected. Openings into the vagina or vulva offer a much better prospect; patients have even been known to live to 100 years, and give birth to numerous children. In the males, as the opening is into the urinary passages, the prognosis is less hopeful, ascending infection of the kidneys being the usual sequel.

From the standpoint of treatment the indications are twofold: To open up a channel for evacuation of the feces, and place the opening at the site of the normal anus, or as close by as possible. Or to put it in another way, make two groups: (a) the intestinal contents cannot be expelled. Here is an absolute obstacle and an equally absolute necessity for immediate intervention. (b) The contents can escape, but through some abnormal opening, or not in sufficient amount. In this case, while there is a grave infirmity, life is not immediately jeopardized and one can choose the opportune time for operation.

Puncture, as Delbet remarks, is rather a method of exploration "than one of treatment." While it has occasionally yielded a satisfactory result, it is blind, unscientific and dangerous, and has been practically abandoned. A case of Cripps may be selected to show its uncertain nature: In a child with a cul-de-sac at the anus, the parents refused operation at first. The child was readmitted on the thirtieth day, a soft elastic swelling being perceptible through the anus. A sharp director was passed up toward the swelling, but gave no relief, and death followed in a few days with symptoms of peritonitis. At necropsy the blind end of rectum was found about 1.5 inches from the cul-de-sac, the puncture had passed into the peritoneal cavity, entirely missing the rectum. According to Keith, there are 2 preparations in the Museum of the Royal College of Surgeons purposely mounted to show perforation of Douglas' pouch or separation of the coats of the rectum.

Incision and perineal dissection are rather the

first stage of the operation than the intervention itself; the bowel still remains to be dealt with. When the rectum ends in a blind pouch, this may be brought down to the perineum, which is possible in 90 per cent of the cases, according to Keith, or by colostomy. The latter again may be done for immediate relief, leaving the imperforation to be dealt with at some future time. Mr. Cripps observes that in his case just referred to, if a dissection had been made up and back toward the sacrum, the bowel might have been found without opening into the peritoneal cavity.

Esmarch and other writers advise waiting two or three days for the meconium to accumulate, thus facilitating location of the bowel. As a matter of fact, the amount grows less with time, on account of absorption of the watery constituents. While it is preferable to bring the bowel down as far as the perineum before opening it, nothing is gained by delaying the operation as is sometimes recommended, as the contents for the first twenty-four hours or so are sterile.

For openings into the bladder, a plastic operation is necessary, approach being made through either the perineum or the anterior abdominal wall. Likewise for openings into the vulva or vagina.

As regards the end-results of operation, the first large series collected was by the late William Bodenhamer of New York in 1860. Of 156 patients operated on, 87 recovered; while of 42 without operation, only 12 lived.

The latest, though now a decade old, are by Hardouin of France. He takes up the survival after 223 operations as follows: Puncture and simple incision, 53; proctoplasty, 73; perineal route, 9; method not stated, 8; iliac colostomy, 63; lumbar colostomy, 10; combined methods, 10. Of these 55.20 per cent lived over a week; 44.40 over a month; 22.80 per cent could not be traced after first year; 13.45 per cent were living over a year; and 5.85 per cent over twenty years.

So the prognosis is somewhat serious. In the first place there are often associated malformations which themselves prove fatal, such as patent foramen ovale, etc. Stricture is common, and the stercoral stasis favors the absorption of toxins and the migration of microbes from the gut, thus weakening the subjects and preventing them from overcoming intercurrent diseases, diarrhea and the like. Therefore, the earlier the operation

the better the result (Matas). Keith states the imperforations appear to react on the child even before birth, and death is frequent even after operation.

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HOW TO STUDY A HEART CASE AND HOW TO TREAT IT.

C. T. HOOD, M. D., CHICAGO.

(Continued from page 125)

IRREGULARITIES OF THE HEART.

The most common cardiac irregularity is the dropped beat, where a beat is apparently dropped in the pulse at the wrist and, after a longer pause than normal, is followed by a strong beat. In others a faint pulsation is felt in the radial, followed by a long pause, then by a strong beat. At the apex the imperfect beat can be heard, followed by a long pause, then by a strong beat. Again, the imperfect beat is not felt in the radial, nor is it heard at the apex, but a flutter may be heard at the apex. This is the so-called "premature contraction," or extra systole.

There are two types of premature beats. One, auricular, which is rare, where some other center than the pace-maker originates the impulse that causes the heart muscle to contract. As this impulse is an imperfect one, the cardiac systole is imperfect, and since this new center does not originate another impulse, the heart pauses until the pace-maker takes up the normal rhythm, hence the pause. The second type of premature contraction results from an impulse that originates in the bundle of His, or from some bit of the original heart tube imbedded in the ventricles, and for the same reason as in the first type, the systole of the heart is imperfect. The heart pauses and a strong beat follows. This latter type of premature contraction is quite common.

So far as the writer has observed, it never occurs in the streptococcus heart. Some writers report finding premature contractions in streptococcus hearts, but the writer believes the dropped beats found in the streptococcus heart are the result of a momentary auricular fibrillation, and are not true premature contractions. They do occur in the nephritic and syphilitic hearts, and are quite often found in the arteriosclerotic heart, but are still more frequently found when no organic condition of the heart is present. The explanation for this is difficult. It may be due to a nervous condition, over-distention of the stomach, an emotional state, the use of tobacco, coffee and tea, and to other causes.

The most valuable diagnostic point, when a polygraphic tracing cannot be obtained, is that the ventricular premature contraction rarely, if ever, occurs while the reserve power of the heart is being used or while the individual is in motion, but occurs immediately after exertion or upon first going to bed. When there are no other positive signs of organic disease of the heart, premature contractions may be dismissed from mind and the patient told that they mean nothing and to dismiss them from his thoughts.

No treatment, so far as we know, has any influence on them. Change of habits, avoidance of excesses of all kinds and attention to elimination produce the best results.

In young people a form of cardiac irregularity is often found, which manifests itself by a rapid pulse for a few seconds and then a slow pulse for a few seconds. By carefully timing the rapid pulse it will be found to correspond with inspiration, and the slow pulse with expiration. This is a sinus arrhythmia, and means nothing.

Spasmodic Tachycardia. This type of cardiac irregularity may be found in any of the four types of organic diseases of the heart, as well as when no demonstrable organic disease exists. The heart's action suddenly increases from seventy-eight or eighty beats to one hundred twenty or one hundred fifty beats per minute, or even higher, for a few moments or an hour or two, then suddenly drops to the normal rhythm again.

The direct cause is that some new center other than the pace-maker suddenly develops an impulse that causes the heart to contract with abnormal rapidity, and this center continues to produce impulses that result in rapid heart action

for a time. Then the new center suddenly ceases its activity, the heart pauses for a longer time than normal, following which the pace-maker again takes up its work and the normal rhythm of the heart is restored.

So far as we know the indirect cause for spasmodic tachycardia is unknown, and we know of no treatment that is of any avail.

After observing a large number of these cases, we have never seen a patient die in an attack, nor have we known of one. Our own experience is that the ice-bag over the heart is as good as any other line of treatment.

Auricular Flutter. This variety of cardiac irregularity is found most frequently in the aged. It is the same as a paroxysmal tachycardia, except that the auricles may be contracting at, say two hundred forty per minute, while the ventricles are acting at one hundred twenty per minute, every other impulse from the pace-maker being blocked in transit to the ventricles.

A flutter may last a few days and may result in death. The direct cause is the same as for spasmodic tachycardia. The indirect cause is unknown. No treatment affects it. Digitalis in small doses may do some good.

Auricular Fibrillation or Absolute Arrhythmia. One of the most important cardiac irregularities is auricular fibrillation, or absolute arrhythmia. This variety of irregularity is due to the fact that the auricles are stimulated so rapidly that they are not able to regain their normal excitability and contractility, and finally reach a state of dilatation and spasm or delirium. Only a few of the impulses that cause the auricle to contract so rapidly are transmitted to the ventricle, and some of these impulses are more perfect than others. The result is an exceedingly irregular action of the ventricle producing an absolute arrhythmia of the pulse. Whether the direct cause of the auricular fibrillation is a delirium of the pace-maker or is due to some new center in the auricle is unknown, but the prolonged continuance of the condition and the influence of digitalis upon it point to the pace-maker as the original cause. Auricular fibrillation is most common in streptococcus hearts. It may occur in the nephritic or syphilitic heart, but it is rare in the arteriosclerotic heart. The writer can recall but one case in which it did not occur in a streptococcus heart.

Diagnosis. The diagnosis is not difficult. The treatment is digitalis, and in no cardiac condition can such brilliant results be obtained as in auricular fibrillation. Elimination should be pushed as rapidly as possible. Croton oil, we believe, is one of the best remedies. Rest having been obtained, the ice-bag may be tried. Sometimes it gives good results. Then digitalis, of a known active preparation, is pushed until the pulse comes down near the normal and is fairly regular; then that amount of the drug is given which will hold the pulse at or near the normal with a fair degree of regularity.

An unusual type of so-called cardiac irregularity is occasionally met with; namely, bradycardia. It is not, strictly speaking, an irregularity but, rather, a slow heart. It is most often congenital or may be due to some pneumogastric irritation. The heart's action is slow—thirty to forty per minute—but it is perfectly regular. The ventricular contraction is blended with and follows immediately after the auricular contraction. There are no other signs or history of organic disease of the heart. It has been known to exist for years. Occasionally we find a bradycardia following a long siege of typhoid fever. Here it may be due to a weakened myocardium, but it requires no treatment except rest. If the bradycardia is annoying, atropin in small doses may give results.

Heart Block. The last of the known cardiac irregularities is heart block. This variety of irregularity may be found in any of the four types of organic diseases of the heart, but the writer has never seen it in any but the syphilitic and streptococcus hearts. The direct cause is a failure of conduction on the part of the bundle of His to convey properly, or not at all, the normal impulses generated in the pace-maker.

It is not an easy task to make a diagnosis of an incomplete heart block without a polygraph or an electrocardiograph. If the bundle of His is only so affected that there is but a short delay in the conduction of the normal impulse generated in the pace-maker, the ventricular contraction follows the contraction of the auricle, but is not blended with it, as in health. The polygram shows a widening of the AC space. If the bundle of His fails to conduct some of the impulses from the pace-maker to the ventricle, an occasional ventricular contraction is missed. If the bundle of His fails completely to transmit every other

impulse from the pace-maker, or every third impulse, or every fourth impulse to the ventricle, the ventricle will contract respectively one-half, one-third or one-fourth, as often as the auricle. This is the incomplete heart block, because when the ventricle does contract it does so as a result of a normal impulse from the pace-maker, but if the bundle of His fails to transmit any of the impulses originating in the pace-maker, the auricle will contract as a result of a normal impulse generated in the pace-maker, but the ventricle will develop a new center out of the bundle of His or its branches, or from some bits of the original heart tube embedded in the ventricle. The ventricle will contract as the result of an impulse generated in this new center; thus, the auricle will have its own rhythm, seventy-two to eighty per minute, the result of impulses generated in the pace-maker; the ventricle will have its own rhythm, twenty-five to thirty per minute, the result of impulses generated in the new center. This is complete heart block.

Treatment. Antisyphilitic treatment and, should a streptococcus infection exist, treatment for this latter infection as well. The writer, however, has never seen a case of complete heart block recover.

Pulsus Alternans. This condition is not strictly an irregularity of the heart but, while the heart's action is regular or nearly so, the systole of the ventricle varies in strength. The most common variety has alternate strong and weak beats. The condition can quite frequently be recognized by the pulse and by the second sound at the apex, but many times it requires a polygraphic tracing to make the diagnosis. Pulsus alternans points to serious myocardial disease. When the condition becomes permanent the majority of individuals suffering from it die within a few months. Digitalis in small doses may be of service in giving some relief to the patient. Rest, with attention to the general conditions, offers all that can be done.

CONGENITAL HEART MURMURS.

Congenital heart murmurs can be heard easily, but they are frequently exceedingly difficult to diagnose correctly. They are loud murmurs as a rule, heard all over the chest and often on the forehead. They may be high-pitched and even musical and most frequently occur with systole,

but occasionally with diastole. The most important diagnostic points are:

First: The history, which should be carefully taken.

Second: As a rule there is no enlargement of the heart.

Third: Cyanosis, especially on exertion.

Fourth: They are most frequently found in the young.

No treatment is known for them.

FUNCTIONAL MURMURS, OR THE SO-CALLED SYSTOLIC MURMUR AT THE APEX.

The older writers classified heart murmurs as organic and functional. There may be a few murmurs where no pathology exists, but after years of experience and many opportunities of observing at the post-mortem table hearts that were supposed to have a functional murmur, the writer has concluded that but few functional murmurs exist.

Certain insurance companies will not accept for insurance a person having a heart murmur, and most military surgeons refuse for service a man with a heart murmur, and many people have been ordered by their physicians to give up their business because of the presence of heart murmurs.

If the reader has read carefully the preceding pages, noting the facts as they have been recited, he will not be likely to make this mistake, for the presence of a murmur alone is no evidence upon which to base a diagnosis of organic disease of the heart.

It is safe to say that diastolic and presystolic murmurs are never functional, leaving only the systolic murmurs as questionable.

Systolic murmurs at the base, unless congenital, which are exceedingly rare, are, we believe, always due to, first, a streptococcus infection; second, a roughened arch; third, a dilated arch; and all these are accompanied by definite and distinctive evidences of changes in the heart's size as well as in the blood vessels, but systolic murmurs at the apex occur where the murmur is the only evidence to be obtained.

They may be due to a weakened myocardium as the result of some general weakened state of the system. They may be due, in children, to imperfect development of the myocardium. They are quite frequently the result of a general anemic state, especially pernicious anemia. They

are not infrequently due to a long-continued nerve strain, but if organic they can be due to but two things: First, a streptococcus inflammation of the valves; second, a stretching of the auriculo-ventricular ring, as a result of hypertrophy and dilatation of the heart.

These pathological changes give positive evidence of their existence, and if care is exercised in the examination, one cannot fail in the majority of cases to establish the fact as to whether the murmur is organic or functional. Great care must also be exercised in estimating the value of exercise in this class of individuals, for the same cause that is responsible for the murmur may also cause fatigue and dyspnea on motion. The fact that the heart does not exhibit positive signs of enlargement, particularly of the right ventricle, does not in itself prove that the murmur is functional. If the heart shows no signs of enlargement and the pulmonic second sound is not accentuated, one may suspect a functional murmur, but if the pulmonic second sound is accentuated, even to a slight degree, the murmur is not functional.

However, it is a grave question sometimes to decide and one that may mean much to the patient. The effect of exercise must be carefully tested. Repeated examinations must be made and the possibility of a tricuspid murmur, due to intrauterine endocarditis, thought of. The heart should be listened to in every position possible, the systolic blood pressure, the diastolic pressure and the pulse pressure carefully taken at intervals, the urinary findings observed, a blood count made, and every possible effort made to rule out changes in the myocardium. If by rest and careful history, as well as a differential blood count and urinary examination, organic lesion can be ruled out, and if by attention to the general condition of the patient, and not his heart, the murmur disappears, it proves that it is functional.

GOITER HEART.

It is not our intention to discuss goiter as such at this time, although no condition presents more varied opinions as to its etiology. But to understand the goiter heart a brief resumé of the subject is necessary.

Practically all authorities agree that there are two types of goiters, exophthalmic and simple, and that the simple goiter may at any time pre-

sent the symptoms of the exophthalmic. In other words, an exophthalmic goiter is a toxic goiter, while a simple goiter is non-toxic, but may become toxic at any time. Without further discussion, the writer, after many years of observation in a large number of goiter cases, concurs in this opinion. First, we have the exophthalmic, that is toxic from its incipency; second, simple goiter, that may become toxic. The so-called goiter heart is due to a thyrotoxicosis, as a result of changes in the thyroid secretion from inflammation or other changes in the gland.

It has been the writer's privilege to observe a large number of exophthalmic cases, quite a few of whom have been operated upon, and to watch the changes resulting therefrom. In many of these cases the exophthalmos is markedly improved, the tremor disappears and the heart's action is quieted down, but still remains irritable. In others, slight effort or excitement causes the heart to become rapid, with all the symptoms of thyrotoxicosis. Again, some of the operative cases take on fat, become apathetic and lose much of their former individuality. Our own observation has been that patients with exophthalmia who are put to bed and have absolute rest enforced, who have the ice-bag placed over the thyroid, and who receive any remedy that may seem to be indicated, especially the hydrobromate of quinine, and who are managed with careful attention to nutrition, elimination, etc., live out their lives. We have seen a few cases where the ligation of one or the other of the arteries of the thyroid has apparently given good results. All kinds of drugs have been used for exophthalmic goiter, but our own experience has been that rest, proper nutrition and the ice-bag produce the best results. After operation many of these cases suffer from insomnia. Here the ice-bag over the gland for an hour or two at night will give rest and the heart will quiet down under its use.

The simple goiter may, by pressure upon nerves, produce irritable heart that is rapid, its valves seeming to close with an abnormal snap. Here the ice-bag will also do good, and the removal of a portion of the enlarged gland give relief and many times put an end to the disturbed action of the heart. If, in the goiter heart, the heart muscle shows signs of poor com-

pensation, digitalis, strophanthus or spartein will be of service. After the patient begins to improve every possible effort should be made to have him avoid excitement of all kinds.

One last word regarding digitalis.

The writer believes that alcohol, to a large degree, inhibits the action of digitalis, and hence, that the best preparations to be used are the infusion of the fresh leaves, the pulverized leaves in capsules, freshly-made pills, or some aqueous or solid form of the drug. There are a number of preparations on the market in pill, tablet and ampoul form. Be sure that your preparation is physiologically active. Do not forget that a tablet dissolved under the tongue will give results almost as rapidly as when given hypodermically and very much quicker than when taken into the stomach.

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PUBLIC HEALTH ADMINISTRATION IN ILLINOIS UNDER THE NEW CIVIL ADMINISTRATIVE CODE.*

C. ST. CLAIR DRAKE, M. D.
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SPRINGFIELD, ILL.

At the last annual meeting of this society I had occasion to present to you a plan for the organization of the State Department of Public Health as would be made possible through the Civil Administrative Code enacted at the instance of Governor Frank O. Lowden, by the Forty-ninth General Assembly.

At that time I pointed out to this society the essential features of the Administrative Code which Governor Lowden has insisted upon having written into the laws at the very beginning of his administration. At that time the Code was not in effect. Theoretically it was sound, but its weakness and strength had never been tested by actual application. The entire nation has watched its enforcement and I think that it is safe at this time to say that it is perhaps the most important piece of legislation having to do with the whole fabric of state government ever incorporated in the laws of any state.

As I stated a year ago, this Administrative

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Code abolished some 240 boards, commissions, bureaus and departments and placed the State government in the hands of eight major departments, each under its director and this director becoming a member of the Governor's cabinet. In most instances the new departments were created by the combining of a number of the old departments or governmental divisions. In the case of the State Department of Public Health the process was one of elimination rather than addition. As is familiar to all of you, the State Board of Health had long been impaired in its efficiency by functions and duties having only an indirect relationship to public health. I refer particularly to the examination and licensure of physicians, drugless healers, midwives and embalmers and the enforcement of the laws relative to the practice of these trades and professions.

Under the Civil Administrative Code, the State Department of Public Health was shorn of all of these extraneous duties and was made a public health department pure and simple, with all of the authority formerly given to the State Board of Health and new and broadened powers, making possible a higher degree of constructive work than has ever been possible in the past.

The program which I laid before you a year ago has been realized in its chief particulars and many new activities have been undertaken and are being successfully carried out which were not contemplated at that time. Many of these new activities have been rendered necessary by the involvement of the United States in the great world war and by the establishment within the State of enormous encampments for the mobilization of the forces of the new National Army. Aside from the ordinary sanitary precautions to be carried out in the zones about these encampments for the precaution of the troops as well as the civil population, certain new activities have developed which have never been given special recognition in military forces in the past. I refer particularly to the control of venereal disease, the control of tuberculosis and a constructive child welfare program, to all of which I shall have occasion to refer later. Those of you who were present at last year's meeting of this society will recall that the State Department of Public Health was to be organized with numerous divisions under the supervision of a director of the department. The Administrative Code also pro-

vided for an assistant director with certain specific duties and a board of public health advisors to be composed of five persons.

The department divides its activities among ten divisions, each with a chief, who is presumably qualified through training and experience to administer the duties of his particular division. These divisions are: 1. The Executive division, including the offices of the director and the assistant director and having general supervision over the entire department. 2. The division of communicable diseases, whose chief acts as State Epidemiologist and as chief of the District Medical Health Officers distributed throughout the State. 3. A division of Tuberculosis whose duties have been greatly increased through the activity throughout the State in the establishment of county tuberculosis sanatoria, county dispensaries and tuberculosis nursing service. 4. The division of Sanitary Engineering, having to do with the control of water supply, sewage disposal, municipal wastes and other urban and rural sanitary problems. 5. The division of Surveys and Rural Hygiene interested in municipal and rural sanitary and health surveys and in the development of sanitary conditions in the rural districts. 6. The division of Diagnostic Laboratories, maintaining a central diagnostic laboratory at Springfield and branch laboratories in various sections of the State. 7. The division of Child Welfare and Public Health Nursing, furthering the conservation of child life and encouraging the establishment of public health nursing service in the various communities. 8. The division of Vital Statistics, charged with the administration of the new state law relating to the registration of births and deaths. 9. The division of Hotel and Lodging House Inspection, confining its activities to lodging houses in cities of over 100,000 population. 10. The division of Public Health Education, translating the activities of every division of the department into a matter of popular interest and promulgating in attractive form material on disease prevention and sanitary betterments.

The Civil Administrative Code became effective on July 1, 1917—less than a year ago, and the program outlined for the State Department of Public Health has been carried into effect. All of the proposed divisions have been created, although in some instances the appropriations made by the General Assembly have been insufficient to organize the divisions as originally contemplated

and desired. The fact that these divisions have been created, however, argues that if they justify their existence by efficient service, ample opportunity will be given in the future for their expansion and development.

Without encroaching upon your time to recite the details of routine activities of the department or to quote statistics or figures, I should like to point out to you a few of those more important developments which have been made possible by the broad provisions of the Code.

The object of the Code itself, upon which Governor Lowden laid great stress, was that of economy and efficiency; the development of team work and coordination of activities and the avoidance of overlapping and duplicated effort. The relationship among the various State departments which has led to these ends has been duplicated among divisions of the State Department of Public Health. The chiefs of the various divisions constitute a sort of departmental cabinet and there has been established a definite spirit and policy of mutual interchange of service and inter-divisional cooperation.

Every division is expected and does render daily service to all other divisions, and while each division is a recognized entity under its chief, the entire department operates also as a unit made up of well-fitted parts.

The peculiar demands of war time which were not anticipated at the time appropriations were made by the General Assembly, have made heavy demands upon all of the divisions and severe drain upon the financial resources of the entire department, entailing to a certain extent the development of ordinary activities as they would have been developed in normal times. And yet these wartime activities constitute the most interesting and perhaps the most important work of the department, not only for the military and civil population of the present, but for the civil population of the future, in that disturbed period of reconstruction which must follow the war.

The department has established sanitary zones about all of the cantonments in Illinois, including Camp Grant at Rockford, Fort Sheridan and the Great Lakes Naval Training Station north of Chicago, the Chanute Aviation Fields at Rantoul, the aviation fields at Belleville, and the aviation camp at Champaign. Sanitary and health officers of the department, including the

epidemiologist, sanitary engineers, surveyors, field workers and nurses, have been assigned from time to time to these zones to carefully investigate the sanitary and health conditions. An exhaustive sanitary survey was made in the Camp Grant zone and a similar survey is now under way in the region of the Great Lakes Naval Station and Fort Sheridan. The exhaustive sanitary investigation of the Kishwaukee River, which crosses the reservation at Camp Grant and which was to have been used for bathing purposes by the soldiers, entailed a vast amount of work, but doubtless prevented serious consequences. The development of communicable disease in the civil population in territory adjacent to military camps or in communities to which the soldiers are in the habit of going, has been carefully watched and the military authorities have been constantly advised of the facts.

One of the most difficult problems connected with the cantonment zones has been the control of venereal diseases, in which the department has cooperated closely with the military authorities and the federal government. Venereal disease has always been a serious military problem, but it was never until the present war that the nations have determined to eliminate these diseases as far as may be humanly possible.

Promulgation of the rules and regulations of the State Department of Public Health for the control of venereal diseases was the first step in the wartime program in Illinois and a drafting of these rules was strongly urged and approved by the federal government. These rules are familiar to all of you. In some instances they have been misunderstood and have created a certain amount of opposition. Once understood, however, they have been thoroughly approved by the members of the medical profession. Aside from being rules desirable in time of peace and absolutely indispensable in time of war, these rules afford advantages of a practical character to the medical profession in that they afford the means of control of the careless or calcitrant patient and do away with one of the most common and most objectionable phases of counter prescribing on the part of the druggist.

The recent ruling of the War Department for the regulation of venereal diseases for a distance of five miles about military cantonments, has imposed new and unusual duties upon the depart-

ment. Special medical inspectors have been assigned to work in conjunction with the officers of the United States Corps for the purpose of examining all prostitutes arrested in these zones to determine the duration of their confinement or incarceration through the orders of the court. Under the present plan all women arrested as inmates of immoral resorts or for vagrancy within five miles of military camps, are examined by inspectors from the department and specimens are promptly transmitted to the laboratory at Springfield. If found infected with either gonorrhea or syphilis, the court suspends sentence and commits them to hospitals for treatment until declared non-infectious by the Department of Public Health. The magnitude of this work and its manifold difficulties will be readily appreciated and these difficulties will increase enormously as war continues.

The activity of the State Department of Public Health in meeting the very real war problem of tuberculosis will be disensed today by Doctor Palmer and I consequently dismiss this subject with the comment that in meeting it Illinois has set the pace for other states.

Unprepared as we are to appreciate the full tragedy of man sacrifice of the war, it is difficult for us at first blush to understand how child welfare work becomes a wartime activity of the first magnitude. This relationship of child welfare and war is fully understood in France, in Belgium, in Germany and in Great Britain. To these nations it is very clear that wholesale depopulation must be followed by repopulation if our nations are to progress and that having sacrificed the very flower of our young manhood we must replace it with a new generation of superior quality. Many of the wartime public health activities consist in merely meeting emergencies as they arise. The wartime child welfare program is as foresighted as it is wise and important. In this wartime child welfare program in Illinois, the Department of Public Health has joined forces with the Woman's Council of National Defense, with the Elizabeth McCormick Memorial Fund and other agencies interested in the conservation of child life. By means of this program and working through the thousands of women registered for war work who are scattered throughout the state, it is earnestly hoped that there will be brought about as the necessary basis,

not only for child welfare work but for all public health work, a hundred per cent registration of births and deaths in Illinois. Incidentally, the state is now put to the extreme test in the matter of birth and death registration. At the present time we are still bearing the odium of being outside the registration area as defined by the United States Bureau of the Census. In times past we used to charge this deplorable situation to unsatisfactory laws. At the present time the law is entirely good and sound. Within the next few months the representatives of the government will carry out investigation in Illinois to determine whether or not registration shall be accorded us and it rests very largely with the medical profession of the state as to what the answer will be. Under the Civil Administrative Code the Divisions of Vital Statistics has developed the machinery to adequately handle the statistical material of the state, so with a satisfactory law, with the machinery ready, the whole question rests upon the interest that is manifested by the people in the medical profession in this tremendously important subject.

It is recognized by the State Department of Public Health that however perfect an organization may be established in Springfield, however efficient the various divisions of the department may be, very little headway will be made in the prevention of disease and the promotion of health throughout the state unless the service of the department may in some way be brought to every community.

Several years ago the State Board of Health established its system of full time medical health officers, each with his own distinct district, the corps constituting a mobile force which could be brought together at any point in the state in time of emergency. At the present time there are six such district health officers and it is to be hoped that this number may be steadily increased. For it is through these representatives of the State Department of Public Health scattered throughout the State, that the most intimate relationship may be established between the department at Springfield and the individual community. But even with the District Health Officer force extended to unlimited proportions, the health service of the state cannot be successful until there is established in each county and in each community a local health organization

which is efficient and responsive. To this end the department is now interested in the creation of state and county collaborating health service. In the creation of this service the entire department will ask each county medical society to delegate one of its members, preferably a man experienced or interested in public health matters, to cooperate with the governmental health agencies particularly to be the point of contact between the State Department of Health and his home county. It is proposed that this state and county collaborating health service shall hold conferences from time to time dealing with public health questions and particularly with those new advances in preventive medicine which require technical instruction or demonstration for their mastery. The first of these conferences will doubtless deal with the advances made in the differential diagnosis and treatment of pneumonia, a subject which is now occupying the attention of scientific medicine.

To the end that there may be efficient local public health administration, the department is deeply interested in the provisions of the law for the creation of sanitary health districts whereby adjacent townships or groups of townships may unite and vote a special tax for the employment of full time medical health officers and all of those things essential for the establishment of a modern public health department.

It is very interesting, if not deplorable, that with the exception of the City of Chicago, there is no Illinois municipality employing a full time medical health officer. At least a score of our cities are amply large to afford the full time service of a competent health official. The vast majority of the state, however, is made up of communities individually so small that the employment of a full time health officer is impracticable. By availing themselves of the excellent provisions of the sanitary health district law, however, there is not a section in the state which cannot have adequate local health supervision and have it without excessive cost, since the size of the district may be determined by those interested in its creation.

The efficiency of the application of this law is guaranteed by the fact that the health officer appointed under its provisions must be selected through civil service and must be a man especially qualified for public health work. Stimulated,

perhaps, by the existence of this law, the City of Springfield has recently made provision for the appointment of a full time medical health officer to be selected through competitive examination by the State Department of Health, and at the same time the state proposes to create at least the beginning of the machinery of a modern municipal health department.

If time afforded I should be very glad to tell you of the general development of the divisions of the State Department of Public Health under the Administrative Code. I should like to have you know of the modern methods of records in the county, especially in the executive division in common with the other departments of the state. I should like to review for you the relatively efficient service of the division of sanitary engineering, crippled though it has been through the fact that its chief for almost a year has been in military service in France. I should be very glad to have you know of the greatly improved method employed in the registration of vital statistics and of the ever-increasing activity of the division of surveys and rural hygiene. I feel that you would be interested in the fact that the State Department of Public Health has created at least a nucleus for a state public health nursing service, and I feel that you would likewise be interested in the clinics which are being conducted in many sections of the state for the re-education of crippled children and victims of poliomyelitis, both of these activities being under the direction of the division of child hygiene and public health nursing. There is a great deal to say of the increased work of the central diagnostic laboratory at Springfield and of the branch laboratories throughout the state, several of which have been added within the past year. It is not improbable that the State Department of Public Health will be in position very shortly to broaden and increase its facilities for laboratory work and to extend its service in supplying preventive and curative biologic products.

In the division of communicable diseases all of the rules and regulations pertaining to communicable disease have been revised in keeping with the rules of the more progressive states of the Union, while the circulars on communicable diseases are being rewritten in accord with the best of modern thought and teaching.

As I see it today the Civil Administrative Code

has been put to the test of practical application under conditions which are unusually exact and the administrative Code has justified all that has been said in its favor. In like manner I am convinced that the form of organization of the State Department of Public Health as presented at last year's meeting of this society has proven itself capable of producing the most efficient health administration for Illinois. If it has failed or if it does fail in this, the fault will not lie with the plan or with the program, but rather with the individuals to whom the carrying out of the program is entrusted.

CASE OF ARTIFICIAL PNEUMO-THORAX OF FOUR YEARS' STANDING. BRONCHO-PNEUMONIA— AUTOPSY.*

ETHAN A. GRAY, M. D.

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CHICAGO.

The patient, Miss R. P., 29 years old, single, housework, previous occupation, seamstress in a factory was admitted to Fresh Air Hospital, April 2, 1913. She had worked the week preceding, and only went to bed on her physician's orders. She stated that she had no knowledge of tuberculosis in her home, although she admitted that she had nursed a consumptive patient some two years before.

Examination: Patient was a small, undersized woman, pale and emaciated. P. M. pulse 124, temperature 99.6, respiration 20; weight 83 pounds. At the first examination the cough was dry, but became moist on further observation.

Physical examination showed the following:

Retractions superior and inferior clavicular bilateral. Apex of heart moderately dislocated to right. Respiratory motion limited right.

Muscle rigidity: left pectoralis major, both trapezii and sterno-cleido-mastoidei.

Left lung: anteriorly, mucous rales at the apex; respiratory sounds diminished in the I, II and III intercostal spaces.

Posteriorly, pitch increased over the scapular region.

Right lung: anteriorly, crepitant rales in the apex, increasing in intensity downwards; cavernous respiration in the III space.

Posteriorly, whispered voice and whisper pectoriloquy at the V space and over the lower third of the scapula; mucous rales from the supra-scapular space down to the 7th rib; cavernous respiration from the 4th to the 7th ribs in the inter-scapular space; fine crepitant rales in the 8th and 9th spaces.

Sputum contained streptococci and tubercle bacilli in numbers corresponding to Gaffky IX.

At the end of two months no improvement had been noted; the temperature averaged 99.6, pulse 112 to 120, and respirations 22 to 28; weight 84 pounds. In view of this lack of progress toward recovery, although the patient was in no way apparently worse, it was decided to attempt a collapse of the right lung. The first administration of gas was successfully performed June 12, 1913.

After eight insufflations, or about July 30, a sero-pneumo-thorax developed. This caused no discomfort, but rendered the further use of gas unnecessary, because the presence of the fluid in the chest produced sufficient pressure to maintain the lung in collapse. After four months there was a material decrease in the daily output of sputum, temperature dropped to normal, while the pulse had fallen to the high eighties. At this time it was also noted that the morning and evening variations of temperature was only 0.6 degree.

On December 18, 1913, it was possible to give 350 c.e. of nitrogen; in January, 1914, the fluid had fallen so far that it was possible to give 750 e.c., while the weight had risen to 99½ pounds. An apparently complete collapse was maintained until May 15, 1914. On this date the patient was discharged from the hospital as a patient and was given employment in the laboratory, where she had become quite proficient. She still slept in the outdoor pavilion but was accepted, otherwise, as an employee.

She received, in all, thirty-seven insufflations of nitrogen, the last of which was given August 30, 1917.

Soon after this time the patient, in a fit of enthusiasm, undertook garden work against advice. It was noted, September 14, that fever was present—likewise fluid in the pleural cavity. Expectoration of this fluid began, which latter proved to be bacillus laden.

On examination, an amphoric tone was heard

*Read before the Robert Koch Society, January, 1918.

in the apex on the right side. This amphoric character was very marked, and was heard also in the first intercostal space.

The chest was punctured as for artificial pneumo-thorax, when the manometer showed at first, positive pressure, then zero pressure—varying with inspiration and expiration. When the patient was moved (or moved herself) from side to side, coughing occurred, followed by the expectoration of a thin, foul, purulent fluid. As above stated, the fluid was heavy with tubercle bacilli.

Diagnosis: spontaneous pneumo-thorax plus artificial pneumo-thorax. Fever remained con-

below the adhesion, anteriorly, a perforation had occurred, making the pneumo-thorax an open one. The cavity thus opened was shallow and thin walled.

The perforation had given rise to the amphoric sounds previously noted, over the first interspace. The diameter of the opening was about one centimeter.

The left lung showed a pneumonia. More than likely the pneumonia was due to aspiration of the fluid from the right pleural cavity above mentioned.

COMMENT.

This patient was brought into the hospital in a condition which we have learned to recognize as unpromising, if not hopeless. After a study of the case the induction of artificial pneumo-thorax was decided upon.

While the brilliant results seen in other cases, such as rapid drop in temperature and pulse, were absent, the main result was satisfactory. The patient lived for four years in comfort, without fever or backset of any kind. She was able to conduct all laboratory examinations of the hospital for over two and one-half years, thereby supporting herself. The cavity discovered at autopsy would, sooner or later, have ruptured and brought the patient's career to a close, even had she not hastened the end by over exertion.

Nevertheless, we show a gain equivalent to the period of usefulness, even though we do not mention her contentment with her situation. Realizing her condition, in her last days, she said, "No one can take away my four years."

Unfortunately, the body was prepared for burial before autopsy could be done. Thus it was that the lungs were found quite hard and difficult to deliver from the thorax.

Note the small size of the right lung as compared with the left. Section through the collapsed right lung showed almost an hepatic structure.

I would call attention to the thickened pleura. Such a membrane will tolerate the presence of an otherwise noxious effusion, without any constitutional manifestation whatsoever.

2733 N. Clark St.

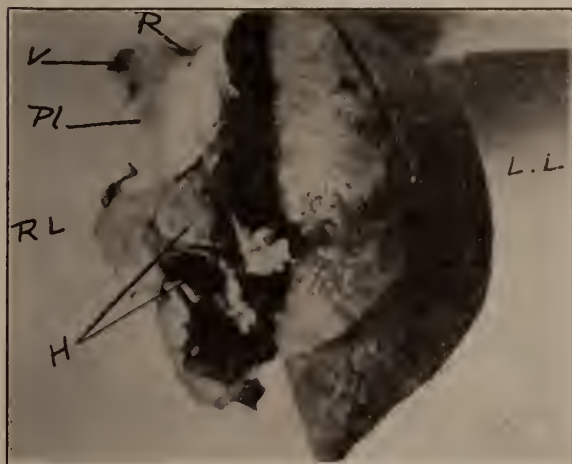


Fig. 1. Lungs and Heart. R. L. Right lung. L. L. Left lung. H. Heart (dislocated). PL. Thickened pleura. V. Vinculum. P. Perforation.

stantly high, 102-103, and continued at that level for three weeks, when death occurred.

Autopsy, October 10, 1917.

On opening the chest the heart and left lung were found to be dislocated to the right. A sero-thorax was found in the right chest; the fluid was rather offensive in odor, and amounted to about 900 c.c.; it was identical with the fluid expectorated during the last weeks of life.

The right lung was collapsed entirely, except for a vinculum 3 cm long and about as thick as a lead pencil; this vinculum extended upwards and outwards from the apex of the lung to the dome of the thorax. The inner portion of the apex was adherent to the dome of the chest. Just

SOME REMARKS ON HYPERTHYROIDISM.*

SYDNEY KUH, M. D.

CHICAGO

The suggestion for the reading of this paper was furnished by our recent experiences on the Medical Advisory Board. We were all of us, I believe, surprised at the large number of cases of hyperthyroidism sent to us for examination, since the belief is so prevalent that exophthalmic goiter is rare in men. True enough—the complete classical picture of that disease we saw but rarely, but there were an astonishing number of cases with just a few symptoms of the malady. Prominent amongst these were tachycardia, goiter, tremor of the hands and infrequent blinking. Many of our subjects, too, presented a slight rise in temperature, the frequency of the latter symptom probably due to the fact that the examinations were all made in the evening. Many of the men were of splendid physique, not a few of them engaged in occupations which demanded most strenuous physical exertion, two of them, seen at the Chicago University, were members of foot-ball teams. Comparatively few of them were conscious of any illness, and one of the foot-ball players became so indignant at my suggestion that he was not a fit subject for the army, that he evinced a strong desire to demonstrate to me that he was perfectly capable of holding his own in a fight. Hardly any of these cases had been recognized by the family physician, and it was only during the last month or so of our work that any greater number of them were diagnosed by the members of the Local Boards. This latter experience coincided with what we see in private practice. Case after case comes to us complaining of some complication but quite unconscious of the existence of any indication of hyperthyroidism. Their family physician has seen them before us, and, often misled by the emphasis laid by the patient upon comparatively unimportant symptoms, failed to recognize the graver disturbance. It seems incredible that a person should have a pulse of 120 or even 140, while at rest, be even

capable of most violent exertions and still be totally free from discomfort, but such has clearly been the case in many instances.

Of the misleading complications, probably the most frequent and important ones are to be found in disturbances in the gastro-intestinal tract. It is perhaps incorrect to speak of them as complications, since they seem to be part and parcel of the underlying disease. I have at the present time two women under my care, who had both been patients of very prominent gastro-enterologists, without receiving material benefit, and who promptly responded to treatment directed at the control of the hyperthyroidism—one with a gain of 16 pounds, the latter in spite of the fact that a recent attack of influenza temporarily reduced her weight by 3.5 pounds. Of other complications seen, which obscured the picture of exophthalmic goiter, because they were responsible for the only symptoms of which the patient complained. I would mention muscular dystrophy; an hysterical pseudo-chorea in a girl of 16; an agoraphobia; the morbid fear of picking up a pocket-book belonging to somebody else and thereby laying herself open to the suspicion of being a thief; the fear of becoming insane; a typical Addison disease in one case, and in another a marked brownish pigmentation of the lower lids; a mucous colitis; in several instances the symptoms of a dementia praecox; attacks of petit mal; a clonic spasm of the sternocleido-mastoid muscle, probably hysterical; manic-depressive insanity; the latter in a case sent to me by a neurologist, who had overlooked the symptoms of hyperthyroidism. That we should occasionally find the latter disease associated with symptoms of dementia praecox, cannot surprise, since simple goiters are surely more common in those who suffer from the insanities of adolescence than they are in the rest of our patients.

In two instances patients complained of marked somnolence in place of the insomnia so commonly found.

What is the cause of hyperthyroidism? In many instances, at least, a careful investigation will show that the first symptoms appeared at about the age of puberty. I well remember a patient, the wife of a physician, who was first seen when

*Read before the South Side Branch of the Chicago Medical Society, Jan., 16, 1919.

about 33 years of age. She had supposedly been ill for a short time only; the cause apparently her second pregnancy. I learned, however, that she had had a moderate degree of tachycardia for many years and when in an attempt to find when the disease really did begin, I asked for old photographs, I found one taken at the age of 17, which distinctly showed both exophthalmus and goiter. After I had called the patient's attention to these findings, she laughingly remarked that she remembered that at that age she had attended her first dance and that then a youthful admirer had told her how becoming the fullness of her neck was. Since then I had often used the same method of investigation and am becoming more and more convinced that in the majority of cases hyperthyroidism has its origin—not in foci of infection in the tonsils, but in that physiological goiter which we see so commonly in pubescent girls. One of my patients—an intelligent young woman—gave a history of recurrent enlargement of the thyroid, first at the age of 15, again one year later, both times subsiding after about six months. A second recurrence led to the more permanent symptoms which brought her to the office.

Another woman of 40 claimed that she had for years noticed a recurrent swelling of the thyroid, always accompanied by hyperidrosis. As a curiosity I should like to mention a case in which an injury to the head was given as cause; perhaps the fact that this was a medico-legal case may throw some light upon the peculiar etiology. One patient, 27 years old at the time of examination, gave a history of having had a tremor of the hands since the age of four. What I saw was the typical tremor of hyperthyroidism, suggesting that in rare cases the disease may begin in early childhood.

The most important and most constant symptom of Graves' disease is undoubtedly tachycardia. Is it always present? A man, aged 35, presents himself for examination, with a history of having had frequent attacks of palpitation without apparent cause since he was 13 or 14 years old. The examination showed: v. Graefe, Moebius and infrequent blinking, some exophthalmus, slight enlargement of the thyroid gland, a fine rapid regular tremor of the hands and a pulse of 68. A case like this suggests the possibility, at least, that the tachycardia may be in-

termittent only. More common undoubtedly are those cases in which we find the pulse-rate only very moderately increased, while the patient is at rest, but quite markedly so upon slight exertion and even more so with every trifling excitement.

Amongst the other important early symptoms, I would like to mention attacks of diarrhea, independent of any error in diet, sometimes seemingly spontaneous, more often perhaps the result again of excitement. Falling of the hair is another very common early sign. Quite characteristic of early gastro-intestinal disturbances is this extract from the history of a patient 21 years old: "For the last three years, while the appetite has remained good, there has been a feeling of distress in the gastric region after meals. During the last months there have been headaches, followed by nausea, chill vomiting dyspnea and violent palpitation."

Some patients will complain principally of vertigo, of pain in the cardiac region, of loss of weight, of sudden attacks of faint feelings, followed by nervous chills, of choking spells.

Very striking and characteristic is a peculiar change in the complexion. A muddy hue of the skin always arouses in me the suspicion of an exophthalmic goiter.

I doubt very much whether any case of hyperthyroidism ever has a persistently normal temperature. It may be normal at the time of examination but if we watch it carefully for a longer period of time, we are sure, I believe, to find an occasional slight rise, a temperature somewhere between 99 and 99.5. This may, and does not infrequently, alternate with slightly subnormal temperatures.

In spite of the fact that I have examined hundreds of cases of hyperthyroidism in the last 15 years, I still meet with an occasional one in which the result of the examination arouses suspicion but does not lead to a definite conclusion. In many of these, if they be women, a simple trick will often lead to the desired certainty. It is well known that in clear-cut cases of exophthalmic goiter, there is usually an exacerbation of the symptoms during the menstrual period. If then you will ask your doubtful case to return at the time of their next menstruation, you will often find the symptoms so definite at that time that the diagnosis can be quite easily made.

Another valuable diagnostic aid, the significance of which seems not as generally known as it deserves to be is the symptom of infrequent blinking, far more common—if I may judge by my personal experience—than any of the better known eye symptoms.

Hyperthyroidism is, I believe, an exceedingly common disease, more frequent in women, undoubtedly, than in men, but far from rare in the latter sex. It is found as a complication in innumerable cases of the so-called functional neurosis, and very often overlooked, because of the tendency to waste little time in the examination of a "neuro." *Formes frustes* are undoubtedly very much more common than the classical syndrome first described by Graves and Basedow. The disease often has a very insidious onset and I have no doubt that many of those who suffer from it, go through life without ever becoming conscious of its existence.

May I close these rambling remarks with a few words about the treatment of the disease? Many years ago I reported a series of some twenty odd cases of hyperthyroidism treated with the serum of thyroidectomized animals. Most of my patients were women of the poorer classes, dispensary cases, with large families and unable to employ servants. In order that the results of the experiments might be as clear as possible, they were encouraged to continue with their house work, nothing was said to them about diet, general hygienic measures, etc.; in other words, the only change that was made in their lives, consisted in the administration of the serum. A marked gain in weight, a decrease in the pulse-rate, etc., gave encouragement. This method of treatment has been continued since then and my experience now is based upon the observation of hundreds of cases. Only recently I saw the first woman to whom I gave the serum seventeen years ago. She is still in splendid health. In these years I have learned one thing, however, about the treatment of such cases. The doses recommended by Mœbius and used by me in the earlier cases, were altogether too small for the best possible results. In place of the 15 drops given three times daily I now usually go up to 50 or 60 drops, and I believe that this serum is by far the best remedy we have for the disease under discussion. I cannot give you accurate figures—my records are partly in the office, partly in sev-

eral dispensaries, and it would be a tremendous task to gather accurate statistics, but it is surely a most conservative estimate if I say that fully 90 per cent of the cases of hyperthyroidism react favorably to the serum. In all of my cases there were but three who objected to its administration because of its taste. One of them, a very neurotic woman, absolutely refused to continue in its use; a second had to discontinue it because it caused nausea; the other one took it under protest. I have seen a harmful result in only one instance; the only one in which we attempted to give the drug hypodermatically. True enough, we have seen relapses, but what method of treatment have we which would justify a promise that the disease would no recur? I am firmly convinced that the serum gives results quite as good as surgical interference, without the dangers of the latter. It fails occasionally and when it does—then, and not until then, I believe, should the patient be sent to the surgeon. 30 N. Michigan Ave.

CONDITIONS ARISING IN THE RECENT INFLUENZA EPIDEMIC WHICH SIMULATED ACUTE ABDOMEN.

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GREAT LAKES, ILL.

In recent years the surgical profession has come to recognize a clinical picture which has been termed "Acute Abdomen" or "Acute Surgical Abdomen." To the surgeon this picture usually brings the conviction that an early operation is indicated.

The time has passed when surgeons waste valuable time quibbling over the finer points which could be elicited to bear out a diagnosis of either a perforated gastric ulcer, acute suppurative cholecystitis or ruptured appendix. They are all operative cases and more than that, they are emergency cases wherein the time element may mean much in the ultimate prognosis. Men with large clinical experiences agree that the ability to recognize the acute abdomen is an asset to the general practitioner, which cannot be appreciated until one has been placed in a position to observe the high morbidity and mortality entailed by the failure of men to recognize this clinical picture.

The acute abdomen as a rule results from an

inflammatory involvement of the visceral or the parietal peritoneum. The most typical examples are those of acute appendicitis and acute perforation of the gastro-intestinal tract.

The cardinal signs and symptoms of acute abdomen vary considerably, depending upon the pathological process in which it has its origin. Pain is usually an early and marked symptom. It may be continuous or intermittent. Sharp colicky pains are more common than dull aching pains. The location of the pain varies; in most cases it is local at first, later becoming general as more and more of the peritoneum is involved.

Muscular rigidity is probably the most valuable of all the clinical signs. It is upon this sign that most men make their final decision. This is admittedly no time to enlarge upon the manner and technique of abdominal palpation, although too often an early diagnosis is bungled by the physician's awkwardness and lack of skill in this particular step. Great care must always be exercised in differentiating between voluntary muscle spasm and the reflex spasm which is due to the attempt of nature to protect deep-seated inflammatory processes. Especially is the foregoing true where the case has been repeatedly examined. Tenderness of the abdomen is usually present and most marked over the area of greatest rigidity.

Nausea and vomiting may or may not be present. A feeling of nausea is, however, nearly always present when any of the hollow viscera are involved.

Fever makes its appearance rather early in the majority of cases. In cases where shock is present a subnormal temperature may be found. In all cases it is well to have the temperature taken per rectum.

A leucocytosis is present sooner or later in most cases. Other symptoms may be present, but the foregoing picture covers the great majority of these cases. It is this picture with which every practitioner must familiarize himself if he is to give his patients the best possible prognosis in acute surgical conditions.

During the recent influenza epidemic I saw in my surgical service at the Great Lakes Naval Training Station Hospital, or in consultation, a considerable number of cases which taxed the diagnostic ability of myself and my colleagues. I shall not attempt to recite individual cases but shall confine myself to a rather arbitrary group-

ing of some of the cases which were particularly puzzling.

The onset of acute chest conditions gave us concern in many instances. They were confused most often with acute appendicitis, although occasionally we were confronted with symptoms resembling acute gall-bladder disease. I have come to have a wholesome respect for the difficulties encountered in making an early diagnosis in these cases. By early, I mean within the first six or eight hours.

The most acute observation is necessary in the obscure case. The following points have served as valuable aids to me. In chest conditions the pain is rarely so well localized over one particular area. Tenderness was present all over the right side in many cases and was more marked on superficial than on deep pressure. The muscular rigidity in the pneumonic cases was nearly always more marked in the upper segment of the right rectus muscle than is found in appendicitis. A temperature which rose rapidly to 103 F. or 103.5 F. during the first few hours always directed my attention to the possibility of a chest condition. A leucocytosis of over 20,000 appearing during the first twelve hours should lead one to make a most thorough examination of the chest for rales, friction rubs or distant bronchial breathing.

In differentiating acute cholecystitis, we depend upon the sharper localization of the pain, tenderness and rigidity to the gall-bladder area. A wait here of a few hours will allow the chest findings to become so marked that the diagnosis is quite clear.

Another group of cases which gave us great concern occurred during convalescence from influenza pneumonia. The individuals as a rule had barely weathered the storm and their resistance was much lowered. Anemia, emaciation and weakness were extreme in these patients. A typical course was one in which the convalescence was interrupted by the onset of a general abdominal pain which many times would later localize more or less over the appendix or the gall-bladder region. Tenderness would develop over the entire abdomen with muscular rigidity which in some cases could be said to be almost board-like. Nausea and often profuse vomiting ensued in from six to eight hours after the onset. The temperature would raise two or three degrees and a leucocytosis either developed or remained as a result of some area of incomplete resolution in

the lungs. Marked distension of the abdomen was present in some, while other cases presented a flat, even retracted appearance. Later the severe cases showed increased meteorism and distension. Obstipation was present but by the use of many flushings some gas and small fecal masses could usually be induced to pass. These cases I believe to have been of two classes. One group probably had its origin in some disturbance in the enervation of the gastro-intestinal tract while the other resulted from degeneration of the circular and longitudinal muscles of the stomach and intestines.

Many of these cases gradually cleared up under general symptomatic treatment. Post-mortem examination of the fatal cases showed about the same findings in each one. On opening the abdomen a moderate amount of turbid fluid was found. The intestines were dilated but no plastic exudate was present. The appendix and gall bladder were examined and showed no changes which could be connected with the recent condition. In one case a large abscess was found in the region of the spleen but it was well walled off and seemed to have been present for some time. In another case a large abscess—probably metastatic—was found in the right rectus sheath posteriorly. The chest usually showed either areas of unresolved pneumonia or abscess formation. To have operated upon these cases would have been a fatal mistake.

In my discussion I have only tried to outline a few of the interesting borderline cases which were so numerous during the recent epidemic. Coming as they did in such profusion I feel that we were more impressed with the diagnostic difficulties than we would have been had we seen these same cases scattered over some considerable time.

In summarizing I consider the following points worth remembering:

1. The possibility of chest conditions giving rise to a clinical picture resembling an acute surgical abdomen.
2. The chest should always be carefully examined before operating on an acute abdomen.
3. A leucocytosis of over 20,000 occurring in the first eight hours of an acute case should direct special attention to the possibility of a chest condition.
4. A temperature of 103 F. during the first

four hours is far more common in chest conditions than in abdominal conditions.

5. Both chest and abdominal conditions may occur simultaneously.

USE AND ABUSE OF PITUITRIN.*

ANNA E. BLOUNT, M. D.

OAK PARK, ILL.

I began to take a keen interest in pituitrin through discovering that a whole rural population where I once lived was suffering from the effects of it.

About three years ago, when visiting my little sister who was awaiting confinement, I learned that she and many of her neighbors were afraid to employ the only country doctor easily available, because as she said, "He gives something that nearly throws the women into convulsions, in order to hurry the birth of babies, and get on to the next case."

I made further inquiries and found that many women whom I had known as little girls were visiting the hospital of the nearest city to have lacerations repaired. Nearly every farm-house had furnished some recruit for that hospital, and some had gone again and again. There were several women left total wrecks by their experience, and the maternal and infant mortality appeared to have been large.

Naturally I advised my sister to resort to skilled help from the city in the first place, instead of going there later for repairs from the damage of pituitrin.

This little vacation sheaf of hearsay evidence led me to inquire of all women in whom I found deep cervical lacerations, as to whether they had pituitrin. There certainly seemed to be a frequent correlation.

We in U. S. have little reason to be proud of our record for maternal mortality, since the children's bureau reported for 1913, 15,000 deaths as a result of childbirth, and that only two other nations among the fifteen most important nations of the world had a maternal death rate equal to ours.

In Porto Rico and Brazil, where midwives use pituitrin freely, numerous deaths from ruptured uterus in the practice of midwives have been re-

*Read before the Aux Plaines Branch of Chicago Medical Society, Dec. 27, 1918.

ported. Marchand of Porto Rico reports two, and Marcondes of Brazil reports five. But in America the great menace to motherhood is the doctor who has not time to wait. After the report of the children's bureau, it is not surprising that an earnest effort is being made to raise the college requirements in obstetrics.

Pituitrin, or liquor hypophysis, is a standardized solution of the water-soluble constituents of the posterior lobe of the pituitary body. In passing we should recall that the pituitary body, a little organ weighing ten grains, lying in the sella turcica of the sphenoid bone, has a double origin, the anterior lobe developing from an infolding of the pharynx, Rathke's pouch, and the posterior lobe being an outgrowth of the brain, its infundibulum being in open communication with the third ventricle in fetal life. The anterior lobe is then glandular in structure, and the posterior lobe contains neuroglia cells, being of cerebral origin. The functions of the two lobes seem to be separate, the anterior lobe being essential to life, its secretion having to do with growth and the sexual development. Absence of function of the anterior lobe means infantilism, while hypersecretion of this lobe causes gigantism. Hibernating animals, as they go into their winter sleep, have a diminution of pituitary function, with the usual human symptoms of such diminution, somnolence, lowered pulse and blood-pressure, lowered tissue-metabolism and body-temperature, and inactivity of the reproductive glands. Just before the spring awakening there is an enlargement and increased function of the pituitary gland.

The posterior lobe has a marked effect in raising blood-pressure, stimulating contractions of the uterus and of all unstriated muscle, stimulating secretion of milk, and sometimes producing polyuria and glycosuria.

During pregnancy and after castration the pituitary body increases in size, usually to twice its original size, and very likely furnishes the normal chemical stimulus to labor.

Pituitrin, the posterior lobe extract, is put up in ampoules of 1 c.c., or 0.5 c.c., as in case of the Mulford product. It is also put up in ounce vials, which are, however, unsatisfactory, their contents often becoming inert. There are about a dozen such products on the market, the British and German products being stronger than the American. In spite of the U. S. P. standard

these products are not very uniform in strength, though they have improved in this respect since Roth in 1914 found some products inert, and some 7.5 times the strength of others. In 1917 Roth examined seven samples of American manufacture, and found four of the required strength, while one had one-tenth, another one-fifth and another one-fourth of the pharmacopeal strength.

The methods of standardization used are measuring the rise in blood-pressure produced, and measuring the effect on the uterus of a guinea-pig, comparing with the effect produced by a weighed amount of one of the crystalline products of ergot (beta-imianazolyl-ethylene-hydrochloride). The blood-pressure method is inexact, however, for Roth found two samples producing equal rises of blood-pressure, one of which produced twice as great effect upon the uterus as the other.

Pattenger says that preparations are now on the market having twice and three times the standard strength. Some of the preparations use both lobes of the pituitary body, and an anterior-lobe product is also on the market.

As a drug, pituitrin is unstable, uncertain and unsatisfactory. It is of varying strength, and the individual reaction to it is always an unknown quantity. At times you may give two or three ampoules, with no result whatever, and at other times a few minims will threaten to rupture the uterus, even with the usual indications fairly met. DeLee reports a case of occiput posterior where 3 minims produced such violent results that ether had to be given to save the uterus from rupture. Each person should employ some one standard preparation, and become familiar with its dosage. As it is dispensed in ampoules, the tendency is to give always too large a dose. A whole ampoule should *never* be given at one time. Bandler, its most eloquent advocate, gives four minims at a dose, repeated every half hour, getting results within four to six minutes, but with occasional cumulative effect. The effects of the drug are usually evanescent, lasting about half an hour, after which the dose must be repeated. Dover gives two or three minims at a dose, and Fred L. Adair gives three or four.

Usually free bowel action follows the use of the drug, but occasionally a depressing action of the drug upon the intestinal musculature is observed, both experimentally in animals, and clinically.

Pituitrin was first used to increase uterine con-

tractions by Blair Bell and Hicks, in 1909, three years after Dale had discovered its action on uterine muscle.

It has been interesting for me to run over as much of the literature of these nine years as I could reach. The enthusiasm for pituitrin has followed what I might well call the *usual symmetrical curve of faddism*. The early accounts of its use were most enthusiastic, it was given in a wide range of cases, and it was hailed as a safer substitute for forceps, and the greatest addition to obstetric knowledge since the cause of puerperal fever was discovered by Holmes and Sommelweis. The crest of the wave of pro-pituitary enthusiasm came about 1914 or 1915, and since then there has been a rapid recession. Bandler,¹ Jour. of Obstetrics, 1915, a most enthusiastic advocate, used it in diagnosis between true and false labor pains, for artificial induction of labor, or as an aid to the process, in abortion, and in order to get to an obstetrical convention at the appointed time. Mundell and Quigley believe that its special field of usefulness is in secondary uterine inertia (where the indication might seem to be for rest and recuperation, instead of for increased stimulation). Kosmak, of the N. Y. Lying-In Hospital, uses it on the contrary only or chiefly in primary uterine inertia, with no obstruction in the cervix or the bony pelvis. He does not use it in secondary inertia, and says: "If the natural forces of labor are unable to expel the child without assistance, their stimulation by the use of pituitary extract is not quite logical."

This would seem a reasonable contention, Pituitary extract being a stimulant, and perhaps the natural stimulant to uterine contractions, may supply stimulation, but can not supply muscular power, if muscular power is exhausted. Kosmak says in this connection, "I am less pessimistic about the drug, than the possibility of ever getting the profession to use it properly."

Perhaps the best final summary of the results of pituitrin administration has been made by Joseph J. Mundell,² Jour. A. M. A., June 2, 1917. He collected reports on 5,245 cases. The first report, in 1914, covered 3,952 cases, with one rupture of the uterus in every 494 cases and one fetal death in every 146 cases. He published the second batch of reports on 1,293 cases in 1916, with one ruptured uterus in every 106 cases, or nearly 1 per cent. and with one fetal death in every 38 cases, and one case of asphyxia pallida in every 32.

One may well ask why the early reports are so much more favorable. The answer is not far to seek, for DeLee mentioned 20 unpublished cases of rupture of the uterus in his discussion of Kosmak's paper at the meeting of the A. M. A. in 1918. It is entirely reasonable to suppose that when favorable reports on pituitrin were coming from all sides, unfavorable ones would be suppressed, as reflecting discredit on the one in whose practice they occurred.

The large percentage of fetal deaths may be attributed to compromising of the placental circulation by violent uterine contractions. Also to premature placental loosening. Convulsions following birth in asphyxia are most common. Occasionally a contraction ring will strangle a child by closing on the neck.

When we add to the dangers from pituitrin that we have just mentioned, namely, death or asphyxia of the child, and rupture of the uterus, that terrible harvest of misery from deep cervical lacerations, one is inclined to question the advisability of using it in any case where the risk involved is not already great. Such would be selected cases of placenta prævia lateralis, premature separation of the placenta, and premature rupture of the membranes, with infection. The other indication of primary inertia, with no obstruction is so rare that manufacturers would go out of the business of producing pituitrin for this anomaly. Also cases of post-partum hæmorrhage and Cesarean section after delivery of the child, and induced labor, after the bags have been introduced, may sometimes be suitable cases.

The contraindications are normal labor, primiparæ, high blood pressure, tumors, contracted pelvis, or any pelvic obstruction, incomplete dilatation of the cervix, and all cases of abnormal presentation.

It is, therefore, as we see, indicated either where it can be administered to the mother and not to the child, or where the risks to the child are already so great that it proves the least of possible dangers.

Summary. The indications for pituitrin in labor have narrowed almost to a vanishing point. Cautious administration in primary uterine inertia, presents the sole general indication before the birth of the child. Besides this it is useful because of its quick action to contract the empty uterus in post-partum hemorrhage, and in sectio

cæsareo before the sutures. It usually needs to be followed by ergot in such cases.

The *dose*, almost invariably too large in the past, should be two to five m., repeated every half hour if needed.

No one can condemn too strongly the widespread use of pituitrin as a hastener of labor for the convenience of an impatient doctor. The custom of so using it is laying waste the womanhood of the country, and making the physician the executioner of the unborn. When so used it is a coward's weapon, for though deadly, its devastating effects may be concealed from the family and friends.

SYPHILIS OF THE RECTUM AND ANUS.

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CHICAGO

Syphilis has been recognized and studied throughout all the centuries and many supposed causes have been described, but since Schaudin and Hoffmann in 1905 discovered the spirochæta pallida, much new information has come upon us. The infection beginning locally soon becomes generalized with widespread local evidences of concentration of the spirochætæ in those areas. At the anus and within the rectum these changes may easily be mistaken for other diseases. Tumors of various sizes and ulcers of different degrees in depth, when seen at the anus and within the rectum, are often confusing, particularly to those who see but few cases of rectal disease and who perhaps think hemorrhoids, irritable ulcer, fistula and cancer the only affections in this region.

About the anus may be found the same skin syphilides as occur elsewhere, but all eruptions are modified in appearance by the action of the heat and moisture and the rubbing together of the buttock cheeks.

Syphilitic ulcerations at the anus may heal without deformity, but within the rectum syphilis always permanently incapacitates that organ, sometimes only partially and in other instances completely destroying its function. This deformity of the rectum is augmented by the constant irritation and infection from the feces as they pass.

Some time ago a young woman with a painful

ulcer at the anus consulted the author. She had suffered with constipation for several years and had frequently used an enema. Her physician had treated the ulcer with local applications and later by operation, but only made conditions worse. A phagedenic chancre was later diagnosed and subsequent history proved this to be correct. We afterwards found how this woman was probably accidentally infected by using a borrowed fountain syringe. There was nothing unusual in her case except the location of the initial sore, and it is mentioned here because the rectal expression of syphilis is not a frequent finding and may mislead, because the early ulcers may be mistaken for irritable ulcers and later ones for tuberculosis or cancerous necrosis.



Fig. 1. Syphilitic mucous patch and porcelain plaque.

Syphilitic new formations are frequently considered malignant. I also speak of this patient because positive evidences of chancres at the anus or within the rectum are usually evidences of unnatural coitus, but they are not always so, and the possibility of infection by means of toilet articles, a syringe tip, clothes, towels or a bathing suit is always to be borne in mind, as also the danger to surgeons of infecting their fingers through cuts or abrasions when examining or operating upon a syphilitic patient. The same chancres, rashes, ulcers and new formations may be found about the anus as occur in other parts of the body, but their clinical picture is modified by conditions peculiar to this region, because of the superimposed infection by intestinal micro-organisms,

the constant abrasions of the surfaces by the feces and the irritation of the intestinal secretions. Syphilis is seen here at all ages, in the inherited or acquired types.

Diagnosis: Any suspicious lesion should be examined for spirochæte pallida and a Wassermann reaction sought in the patient's blood and spinal fluid, and be it remembered that a negative result of either or both of these examinations does not assure us that the lesion is not syphilitic. All of the morbid changes of the several stages of syphilis may appear at the anus and rectum and it is therefore vitally important that the examiner wear gloves when exploring these parts.

Chancre: Chancres on the skin about the anus are dependent upon an abrasion being present at the time of exposure to infection. Within the rectum the mucous membrane may also be directly infected. The abrasion in the skin or mucosa may heal in a few days without any visible scar and later, (after one to four weeks) the chancre appears at the same site.

Chancre at the anus occurs frequently enough to be always thought of when an ulcer is seen at or about this opening. Its existence in men is almost proof positive of sodomy, but in women it may occur by accidental contact with the male organ or from vaginal discharges. The chancre may occur on the skin near the anus, between the radial folds, or on the mucous membrane in the anal canal. On the free skin it resembles in appearance a chancre situated elsewhere, but when located between the radial folds or at the anal border it closely resembles an anal fissure. The differentiation is not easy, especially if seen before the induration has developed about its base. It begins as a tiny vesicle accompanied with thickening or infiltration of the skin. Later the blister turns brown, and as the scab separates it leaves a shallow ulcer. The surrounding ring of induration always persists. Chancres, like other ulcerations in this region, vary considerably in the pain they cause, some individuals being more sensitive to pain than others. Also the degree of pain of any ulcer depends upon its depth. If the chancre be located out on the skin, away from the anus, it may cause only slight discomfort, and also if at the anus, provided it involves only the mucous membrane, but if it goes through the mucosa and especially if it involves the musculature, either by ulceration or

by the fixative leucocytosis about the ulcer, it is certain to be painful. If the induration surrounds the muscle fibers it immobilizes them, and by squeezing the fine nerve fibers produces the same sensation as an exposed filament. The chancre in the young woman referred to above was quite as painful as an irritable ulcer.

Chancre at the anus is more frequently observed than within the rectum. Its clinical course at the anus is the same as chancre elsewhere, and on healing there remains a small bluish white scar which is difficult to find later. For this reason the diagnosis often cannot be made afterwards.

In other instances the hard contracting scar may cause stricture (Malsbary, 5).

Chancre within the rectum is rarely seen because it may occasion very little discomfort, only a slight discharge, and may disappear spontaneously. The ulcer has the usual chancre appearance—round, indurated, with sharp raised edges slightly undermined. If it develops on a prolapsing internal hemorrhoid it may be mistaken for a traumatic ulcer. The enlarged inguinal and sacral glands can always be found and are valuable differential information.

Secondaries: In the secondary stage of syphilis we find two forms of ulcerations:

1. The mucous patch.

2. The large ragged ulcer, a sequence of necrosis produced by the strangulation of circulation in the tissue surrounding the syphilides.

1. Mucous Patch. Two to ten weeks after the infection there is sometimes found at the mucocutaneous junction an erythema which might be mistaken for acute eczema. In a couple of days little vesicles appear which break down and leave red and gray sores, irregular in outline and upon an indurated base. They may be single or multiple. If multiple each ulcer will preserve its form even though it be close to another. The edges are not undermined and the intervening tissue remains healthy. When the vesicles rupture there is a thin, fetid discharge which keeps the parts wet and macerated. As the ulcers enlarge they become saucer-shaped, covered with a grayish white membrane, and are termed plaque porcelaine. The discharge and moisture of the opposed buttock produces an hypertrophy, and before the mucous patches are healed there develop broad, flat warts, the condylomata lata.

This condition, although resulting from a syphilitic lesion is not itself syphilitic, and is not amenable to antisyphilitic treatment.

Case C. 21, aged 19 years. For the past three weeks she has had a constant burning pain in the rectum and at the anus, also a bloody discharge. Defecation is very painful. On inspection there is found in the right posterior quadrant of the anus a bright red ulcerated area, extending from the anal canal to well out on the skin. A dense infiltration surrounds this ulcer and its edges are raised. There is also a large white area on the side of the right buttock. A macular eruption is found on the patient's upper body. Diagnosis—Syphilitic mucous patch at the anus with plaque porcelaine on the buttock. (See Figure 1.)

Mucous patches within the rectum are very rare, Molliere (Tuttle) has reported only one case.

2. Ulcerations Secondary to Other Syphilides. When the mucous patch appears there also develops the surrounding congestion which interferes with the local circulation, and sometimes the tissue sloughs away. This may happen with any syphilitic eruption about these parts, i. e., papular, macular, pustular or the small moist papules that appear at the anal folds, on the inner sides of the thigh or about the genitals in any case of syphilis regardless of the location of the chancre. The resulting ulcers are gangrenous, gray in color, irregular in outline, and ooze blood on slight touch. Spirochætæ are present in all these lesions which are therefore ready sources of infection.

Within the rectum the cellular infiltration and induration produce an edema of the mucous membrane. This swelling increases friction, and necrosis is produced usually in several places. The ulcers are regular in form, circular in outline, with clear edges, and usually the whole trouble is confined to the mucous membrane. If seen early they are amenable to treatment and may heal with very little resulting scar.

As has been mentioned above, these ulcers cause few symptoms and therefore often go untreated until they have enlarged both on the surface and in depth, and until they may have extended through the deeper coats of the rectum and even into the pelvic structures. If they are on the anterior wall of the bowel, the peri-

toneum may be opened and infected; if on the posterior wall, the sacrum may be laid bare. If the patient also suffers from some other systemic disorder such as nephritis, tuberculosis or anemia, the ulcer may spread out almost unlimitedly. Kelsey, quoted by Tuttle, reported a case where the whole rectum was circled. The favorite location for these ulcers is about one inch above the sphincter, but they are found less frequently higher up, even to the colon.

These ulcers are sluggish in appearance, with sodden surrounding tissues, and are usually chronic although not always. Occasionally one is phagedenic for the reasons already assigned. Ulcerating syphilides are liable to be confounded with tuberculous ulcers. Paget in his classical differentiation says they have sharp, well defined edges with level base. This is in contrast to the ragged, undermined, and indurated edges of tuberculosis. If several of them coalesce, they appear as one large ulcer, or as a lobulated ulcer, but they do not encircle the bowel as does the tuberculous. On the other hand, if tuberculosis has existed long enough to produce a number of ulcers in or about the rectum or a large excavating one, we will find tuberculosis in other organs. There is considerable purulent discharge from the tuberculous ulcer. The syphilitic ulceration produces a thickened leathery feel to the bowel, but tuberculosis does not affect the elasticity of the rectum.

At this time the lymphatics are much enlarged and may be mistaken for abscess or gumma. From these ulcers there is an abundant discharge of greenish pus, tinged with blood, and having a fetid, disgusting odor, which is characteristic and very different from that of carcinoma or the ordinary rectal abscess. Infection of the deep lymphatics may occur and end in abscess and fistula. Such fistulas are often unresponsive to surgical treatment unless combined with anti-syphilitic medication. If ulceration progresses to this advanced stage stricture of the rectum is inevitable.

Treatment: In the treatment of these conditions rest and the removal of all irritating material from the intestinal tract are essential and also the interdiction of such articles of diet as might be a source of irritation later. The rectum should be frequently irrigated with some bland antiseptic, such as iodoform and ichthyol emul-

sion in olive oil, or a dry powder of iodoform, boric acid and the stearates insufflated.

When the ulceration is considerable the author does not hesitate to make applications of silver nitrate, thirty to sixty grains to the ounce, to the ulcers, repeating them every two or three days, and dressing the surface thereafter with one of the above mentioned powders.

IS IT WORTH WHILE TO STUDY THE INSANITIES BY THE SCIENTIFIC METHOD?

(Concluded from page 173)

suggested to the Institution (1916) that the experts in the laboratories be set at work under the direction of amateurs or even those who have not reached that earliest stage of capacity in science."

"If any good work is required the best way to get it done is to commit it to competent men not otherwise occupied. Large and difficult undertakings demand foresight, oversight, prolonged effort and corresponding continuity of support. The idea that discoveries and advances are of meteoric origin and that they are due chiefly to abnormal minds has been rudely shattered by the remorseless experience of the Institution (1916).

In another matter of vital importance Woodward is equally clear and decided. He considers the autonomy of research within the limits of an annual appropriation as a fixed necessity to efficiency. "Autonomous freedom and reciprocal accountability are the essentials of each research department."

It seems incredible that forty-eight independent states are expending annually one-third of their total annual state budgets on the insanities, and that not one of them has established a Research Institution designed to discover the causes, the cure and the possibilities of prevention of these diseases.

If the reader would advance the time when a portion of the 70,000 now committed annually to a pessimistic and hopeless custody will be saved to normal life, he may do so by urging upon the present State Legislature the passage of House Bill 353. This bill provides for a research laboratory under the Board of Natural Resources and Conservation to expend less than 2 cents for research for cure and prevention for

every dollar expended by the Department of Public Welfare in Custody and Confinement. Write your Representative or Senator—and do it now. If you have taken part during the past ten years to committing a stricken one to the State Hospital, put yourself in his or her place and write as you think he would write had he a mind and means.

There are more than 15,000 families in the State of Illinois from which patients have been taken to the State Hospitals during the past ten years with conditions or diseases of unknown origin, and no cure. What would happen if you could point out now the 4,000 families in which during each succeeding year insanity will appear? Would they write 4,000 letters begging the legislature for relief? If one of those families was yours, what would you do?

JOINT INFLUENZA COMMITTEE

Washington, D. C., February 20, 1919.—A Joint Influenza Committee has just been created to study the epidemic and to make comparable, so far as possible, the influenza data gathered by the Government departments. The members of this committee, as designated by the Surgeon General of the Army, the Surgeon General of the Navy, the Surgeon General of the Public Health Service, and the Director of the Census, are: Dr. William H. Davis, chairman, and Mr. C. S. Sloane, representing the Bureau of the Census; Dr. Wade H. Frost and Mr. Edgar Sydenstricker, of the Public Health Service; Colonel D. C. Howard, Colonel F. F. Russell, and Lieutenant Colonel A. G. Love, United States Army; Lieutenant Commander J. R. Phelps and Surgeon Carroll Fox, United States Navy.

SURE CURES.

There is a cure for every ill that gives your frame a wrench; a porous plaster or a pill, a capsule or a drench. No matter what disease you have, some delegate is nigh, to tell you of a healing salve that makes your anguish fly. Some learned physician has the dope—it costs one buck a throw—that will revive the springs of hope and abrogate your woe. Some ancient dame in humble garb can brew a magic tea, the essence of some mystic yarb, to cure your housemaid's knee. Why do we die before our time and fill the boneyard lot when there are remedies sublime, that always hit the spot? I buttonholed the village doc, and asked him things like these; for I was full, from neck to hock, of every punk disease. "That's easy," said the doc, "you hick; men's judgment is so poor; they always wait till they are sick before they take the cure."

WALT MASON.

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APRIL, 1919

Editorial

ANNUAL MEETING.

Attention is called to the annual meeting of the Illinois State Medical Society, which is held in Peoria, May 20, 21 and 22. The profession of Peoria have been making plans for several weeks for the entertainment of this convention. The

general meetings will be held on the main floor of the Shrine Temple, which is amply large enough to care for the needs of the convention. The space for the exhibitors and the registration desk is arranged for in the basement. Visitors will please go to the Shrine Temple at once on arrival and register so that the Committee on Arrangements will know as soon as possible how many they will have to care for.

Peoria has a great many hotels and is better fixed in this way for the entertainment of a large convention than any city in the state outside of Chicago. It is beautifully situated on the Illinois river and has many historic spots connected with



Fig. 1. The Shrine Temple.

the early history of the state. It is a city of schools, churches, recreational points, parks, driveways, and everything of this character which contribute to the "finer things of life."

Peoria's chief industry is the manufacture of agricultural implements, being first in the manufacture of diversified manufacturing industries and third in aggregate output—Chicago and the tri-cities being first and second. Peoria is the home of threshers, drills, seeders, plows, cultivators—more kinds of implements than made in any other American city, and is fast becoming the home of the tractor. The great Avery company and the equally great Holt company seem to be furnishing the powerful tractors for the world's agriculture, road building and the world's commerce. Tractors of the watch charm variety to the tremendous leviathan—the tiny tractor used in Italy to cultivate grapes and strawberries, and the awful monster of unspeakable power better known as the tanks, which wrought so much havoc for independence and democracy on the bloody fields of France.

Peoria grinds corn for millions of acres. Peoria is fast becoming known as a cereal center. Her receipts and shipments of corn and oats during the past two years have ranked without variation, at the very top of the list of cities, including Kansas City, Chicago, Omaha and other big grain points.

Other articles of manufacture are wire and steel and all kinds of iron and steel products, castings, malleables, furnaces, stoves, structural steel, wire bail ties, wire rope and kindred products.

Peoria has four paper mills: is developing a leading position in the textile industry and in the manufacture of metal novelties, automobiles, wagons, sash, doors and blinds, cordage twine and rope, washing machines, etc.

Peoria has three large splendidly equipped general hospitals, two sanitariums devoted to the care of diseases of the nervous system, one new tuberculosis hospital and a large state hospital for the care of the mentally afflicted.

Peoria claims one hundred thousand population, but Peoria insists that people do not make a city. It is the spirit of the people and Peoria would offer to the world and her visitors the fact that in Peoria it is an unusual spirit which has brought about fellowship and co-operation, where competition is no longer the life of trade and where exists the rarest brand of hospitality and good cheer, which it is hoped will be partaken of by hundreds of members of the Illinois State Medical Association during the May convention.

The Committee on Arrangements has arranged an auto drive for the ladies to the Country Club on Wednesday, May 21, where tea will be served at 4:00 P. M. sharp. The automobiles will leave the Jefferson Hotel at 1:30 P. M. and take the ladies on a drive through the parks, prior to tea. As soon as the president's address is finished at the Shrine Temple Wednesday evening, all the members and their friends will be invited to the Coliseum. Arrangements have been made for a smoker for the men on one side of the assembly room and a place for the ladies to visit on the other side. An old-fashioned dance has been arranged for all on the floor of the assembly room. Some have called this an indoor picnic, but the profession of Peoria want the visitors to call it a good time.

RESOLUTIONS OF THE COUNCIL OF THE CHICAGO MEDICAL SOCIETY.

PASSED APRIL 8, 1918.

WHEREAS, The consolidation act has brought to the department of Registration and Education a centralization of power, too dangerous to be tolerated in a free State, a concentration of power which amounts to a one man control of educational system of the State of Illinois, and

WHEREAS, The Director of the Department is assuming autocratic power and a dictatorial attitude never contemplated or deemed possible when the consolidation act was enacted, and

WHEREAS, The centralization of power placed in the hands of the Department of Registration and Education is too great and must not be continued, and

WHEREAS, The Director of Registration and Education has demonstrated that he possesses a very narrow perspective, a lack of ability in the management of medical affairs and the lack of a judicial temperament necessary for an executive officer; all taken together illustrating beautifully another of the instances of the failure of the college professor in governmental position, and

WHEREAS, It has been demonstrated that the Department of Registration and Education of Illinois has not the confidence of the medical profession of the State, and

WHEREAS, It will be impossible to re-establish confidence between the medical profession and the Department of Registration and Education while either the present Director or the Superintendent of Registration is connected with the Department officially or otherwise. Therefore, be it

Resolved, That the CHICAGO MEDICAL SOCIETY express a lack of confidence in the Director of Registration and Education and the Superintendent of Registration; be it further

Resolved, That the CHICAGO MEDICAL SOCIETY go on record as in favor of taking out of the Department of Registration and Education, the Departments of Medical Licensure, Hospital Standardization and Control, and have them made a Bureau or Bureaus of the State Depart-

ment of Health where they legitimately belong and where they should have been placed originally.

Moved and seconded that the Resolutions be adopted.

Passed.

Moved that a copy of these resolutions be sent to the Governor and the Chairman of the Judiciary Committees of the House and Senate and published in the *Bulletin* and in the ILLINOIS MEDICAL JOURNAL.

EYE, EAR, NOSE AND THROAT SECTION.

Clinic. On Tuesday morning, May 20, as has been the custom, this section will have a clinic at St. Francis Hospital beginning promptly at nine o'clock. In the forenoon, ear, nose and throat cases will be demonstrated and operated upon, and in the afternoon the eye cases will be treated and operated upon. These clinics will be conducted by some of the ablest clinicians in the state and have always proven worthy of a large attendance. This year will be no exception. Any physician in the state who is a member of the state society and who wishes to present any cases, is cordially invited to make arrangements with Dr. Charles D. Thomas, Central National Bank building, Peoria, Illinois, who is chairman of arrangements for the meeting of the Eye, Ear, Nose and Throat Section in that city.

Banquet. Tuesday evening at six-thirty o'clock, there will be a banquet at the Creve Cour Club. Tickets will be three dollars per plate. There will be music, oratory and general good fellowship in abundance and an excellent dinner, such as the club is celebrated for providing. It is one of the great privileges of the year to be present at these splendid affairs and enjoy the fellowship of your colleagues. Please send your check for a reservation to Dr. Charles D. Thomas, Central National Bank building, Peoria, Illinois, who is chairman of arrangements for the banquet.

Program. Wednesday morning at nine o'clock, May 21, the Scientific Program of the Eye, Ear, Nose and Throat Section will open in the Gold Room of the Hotel Jefferson and continue until twelve o'clock, when an intermission will occur for dinner until one-thirty o'clock. The session

will then resume and continue until five o'clock. The program, which has been prepared with the greatest care, will present the most interesting and important phases of progress in our specialties. You are urgently requested to be present and participate in this meeting, which has proved an inspiration to all and amply repaid those who have made the effort to attend heretofore. The presentation of papers will be limited to ten minutes and the opening discussions to three minutes.

DR. WESLEY HAMILTON PECK,

31 N. State Street, Chicago, Chairman.

DR. FRANK ALLPORT,

7 West Madison Street, Chicago,

Secretary.

SMALL CLAIMS COURT.

A problem which is at least partially solved by changes in court procedure arises out of collection of small fees. The Municipal Court of Chicago now has a Small Claims Court, in which all cases under \$200.00 can be tried on the return day unless the defendant asks for a jury. That he will do so is rather unlikely, as it involves payment of extra fees on his part.

The court encourages parties to appear in these cases without attorneys, and to submit the cases on the return day in an informal way. A physician having a bill for collection, which he desires to prosecute promptly and without intervention of attorneys, can secure quick action by just going to the Municipal Court of Chicago, applying at the Information Desk in the Clerk's office, where proper blanks can be secured, and it will be necessary only to go armed with an itemized bill and the name and address of the patient, together with necessary fees, to start suit. By being present again on the date fixed for trial of the case, the usual procedure is for the court to call the defendant and ask him why the bill should not be paid. If he has any good reason, the court hears it; if he does not give any reason, the judgment is entered. The whole procedure is informal and is designed to eliminate attorneys. For a prompt collection of undisputed claims and bills, this procedure is recommended to the profession in Chicago as speedy and effective.

ROBERT J. FOLONIE.

Illinois State Medical Society

PRELIMINARY PROGRAM

SIXTY-NINTH ANNUAL MEETING

Peoria, May 20, 21 and 22, 1919.

SURGICAL SECTION.

Wednesday, May 21, 1919, 9 A. M.

The Selection of a Practical Method of Blood Transfusion, illustrated by Motion Pictures—Karl F. Snyder, Freeport. Discussion—C. H. Hopkins, Chicago, and W. F. Grinstead, Cairo.

Some Phases of War Surgery—Nelson M. Percy, Chicago. Discussion—Lieut. Col. Dean Lewis, Ft. Sheridan.

Surgical Treatment of Gastric Ulcer, with report of cases—W. J. Carter, Mattoon. Discussion—T. A. Bryan, Mattoon, and W. R. Marquardt, Elmhurst.

Oration on Surgery—Jabez N. Jackson, Kansas City, Mo.

Medical Lessons from Our War Experience—C. W. Barrett, Chicago.

The Development of the Colon and the Surgical Importance of Non-rotation of the Colon—F. Buckmaster, Effingham. Discussion—A. D. Bevan, Chicago.

Special Anesthesia in General and Genitourinary Surgery—John S. Nagel and George F. Thompson, Chicago. Discussion—George W. Green, Chicago, and Wm. Allen Pusey, Chicago.

Thursday, May 22, 1919, 9 A. M.

Chronic Pancreas—Hugh MacKechnie, Chicago. Discussion—C. E. Humiston, Chicago, and Hyde West, Woodstock.

Infections of the Gallbladder and Their Treatment—Franklin P. James, Peoria. Discussion—J. V. Fowler, Chicago, and H. D. Junkin, Milford.

The Habitat and Distribution of Dangerous Streptococci in the Body—D. J. Davis, Chicago.

Surgical Treatment of Enuresis in the Adult Female—F. C. Schurmeier, Elgin. Discussion—H. L. Kretschmer, Chicago, and John S. Nagel, Chicago.

Combination of Radical Surgery and Roentgen-therapy in Recurrent Deep-seated Inoperable

Carcinoma—Emil G. Beck, Chicago. Discussion—J. F. Percy, Galesburg.

Cesarean Section—Chas. E. Parker, Sterling. Discussion—C. E. Paddock, Chicago.

The Dakin-Carrell Treatment of Infected Wounds—Wm. Fuller, Chicago. Discussion—J. W. Van Derslice, Oak Park, and J. B. Bacon, Macomb.

Pelvic Inflammation in Women from the Standpoint of the General Surgeon—H. N. Rafferty, Robinson. Discussion—Frank P. Norbury, Springfield.

MEDICAL SECTION.

(Subject to be announced later)—Carl E. Black, Jacksonville.

Sammelweis and His Fight for Asepsis—C. B. Johnson, Champaign.

(Subject to be announced later)—C. St. Clair Drake, Springfield.

The Medical Officers' Training Camp—J. M. Hoyt, Nokomis. Discussion—Mark Goldstein, Chicago.

Bilateral Pneumothorax—Wilson Ruffin Abbott, Springfield. Discussion—George Thos. Palmer, Springfield.

The Unwarranted Sacrifice of the Tonsil, with illustrative charts—H. M. Harrison, Quincy.

A Resume of the Year's Work in Radium Therapy—C. W. Hanford, Chicago. Discussion—Albert W. Meyer, Bloomington.

Congenital Syphilis—Robert Krost, Chicago. Discussion—Joseph Brennehan, Chicago.

Some Army Aspects in the Prevention and Treatment of the Pneumonias and Influenza—W. W. Hamburger, Chicago. Discussion—G. C. Craig, Rock Island.

Experiences with Yellow Fever in Ecuador—Chas. A. Elliott, Chicago.

Syphilis, a Factor in Gastro-Intestinal Disturbances—M. H. Mack, Chicago.

Neurological Subject—Wm. G. Stearns, Chicago.

SECTION ON EYE, EAR, NOSE AND THROAT

Wednesday, May 21, 1919

Serpiginous Ulcer of the Cornea and Treatment—Willis O. Nance, Chicago. Discussion—George W. Mahoney, Chicago.

Mastoiditis, Its Diagnosis and Treatment—Richard J. Tivnen, Chicago. Discussion—Thomas O. Edgar, Dixon.

Various Phases of Myopia—Heman H. Brown, Chicago. Discussion—Michael Goldenburg, Chicago.

The Illinois State Institution for the Blind—A. L. Adams, Jacksonville. Discussion—Walter L. Frank, Jacksonville.

Glaucoma—H. W. Woodruff, Joliet. Discussion—Edward F. Garraghan, Chicago.

Binocular Cataract Operations—John R. Hoffman, Chicago. Discussion—Dwight C. Orcutt, Glencoe.

Hyperæsthetic Rhinitis—Harry L. Pollock, Chicago. Discussion—Otto J. Stein, Chicago.

Immediate Closure in Acute Mastoiditis—J. Sheldon Clark, Freeport. Discussion—John F. H. Deal, Springfield.

Is Malaria an Etiologic Factor in Iritis?—R. C. Matheny, Galesburg. Discussion—James W. Dunn, Cairo.

Results from Tonsillectomy and Adenectomy—C. F. Burkhardt Effingham. Discussion—C. B. Voigt, Mattoon.

Modern Surgical Technique in Tonsillectomy—J. Z. Bergeron, Chicago. Discussion—Henry R. B. Boettcher, Chicago.

Iritis—Alfred N. Murray, Chicago. Discussion—Francis Lane, Chicago.

Cocaine Anesthesia in Nasal Operations—A. H. Andrews, Chicago. Discussion—Arthur M. Corwin, Chicago.

Submucous Operations—Oliver Tydings, Chicago. Discussion—B. F. Andrews, Evanston.

Early Extraction of Traumatic Cataracts—Thomas Faith, Chicago. Discussion—Charles H. Francis, Chicago.

Eye Involvements Following Focal Infections—E. R. Crossley, Chicago. Discussion—Frederick D. Vreeland, Evanston.

Sphenoid Sinus Diseases. Exhibition of Sections—John A. Cavanaugh, Chicago. Discussion—Charles B. Younger, Chicago.

Radium in Eye, Ear, Nose and Throat Diseases—Edward E. Edmondson, Mt. Vernon. Discussion—Otto T. Freer, Chicago.

Optic Neuritis, Etiology of Diseased Tonsils—Carroll B. Welton, Peoria. Discussion—David Salinger, Chicago.

Influenza—Charles H. Long, Chicago. Discussion—J. Whitefield Smith, Bloomington.

SECTION ON PUBLIC HEALTH AND HYGIENE

W. H. Cunningham, Rockford, Chairman.
G. G. Burdick, Chicago, Secretary.

First Day

SYMPOSIUM ON INFLUENZA AND PNEUMONIA

The History of Influenza with Statistics on the Pandemic of 1918-1919—Wade H. Frost, U. S. Public Health Service.

The Attempt to Control the Epidemic in the Nation at Large—Allen J. McLaughlin, U. S. Public Health Service. Discussion—John Dill Robertson, Chicago.

The Attempt to Control the Epidemic in Illinois—John J. McShane, Springfield. Discussion—W. C. Clarke, Cairo.

Our Present Knowledge of the Bacteriology and Pathology of Influenza and Its Complications—Joseph F. Biehn, Chicago. Discussion—Arthur Isaac Kendall, Chicago.

The Prophylaxis and Treatment of Influenza and Pneumonia: (a) Prophylaxis—Herman N. Bundesen, Chicago. Discussion—J. E. Siegel, Collinsville. (b) Treatment—J. O. Cobb, U. S. Public Health Service.

The Aftermath of Influenza and Pneumonia—Frederick Tice, Chicago. Discussion—C. T. Foster, Rock Island; George W. Parker, Peoria, and C. W. East, Springfield.

Second Day

The Local Health Officer and His Problems—E. W. Weiss, Ottawa. Discussion—A. L. Mann, Elgin.

Three Typhoid Fever Outbreaks in an Illinois City—M. J. Sjoblom, Springfield.

The Relation of the Physician to Public Promotion—H. N. Heflin, Kewanee. Discussion—H. M. Orr, LaSalle.

Proposed Sanitary Legislation—C. St. Clair Drake, Springfield. Discussion—J. A. Wheeler, Springfield.

Title to be announced—Charles J. Whalen, Chicago.

The Laboratory as an Indispensable Institution in Public Health and General Medical Service—Martin Dupray, Springfield. Discussion—F. O. Tonney, Chicago.

Tuberculous Infection, Its Relation to Public Health—Walter B. Metcalf, Chicago.

Encephalitis Lethargica—S. S. Winner, Chicago. Discussion—Peter Bassoe, Evanston.

General Health Activities and Their Effect on Tuberculosis—George Thos. Palmer, Springfield. Discussion—F. M. Meixner, Peoria.

SECRETARIES' CONFERENCE

Reasons Why Some Physicians Do Not Attend Medical Societies—H. A. Chapin, Morgan County.

Alive or Dead—E. W. Fiegenbaum, Madison County.

The Secretary's Relation to the Legislative Committee—Don W. Deal, Sangamon County.

A Plea for Greater Efficiency in County Society Officer—C. W. Lillie, St. Clair County, Councilor, 9th District.

A PLEA FOR A RESEARCH LABORATORY.

In this issue appears an article from Dr. Bayard Holmes which every doctor and every layman in Illinois should read. The care given the insane people of this country in this age will never be referred to as one of the examples of brilliancy. It is a reflection on the medical profession that the insane of today are not better treated.

Where is there an individual of sound mind, if incarcerated in one of our insane wards with nothing to occupy his mind, whose brain will not deteriorate? Why should not science clear up many of these deranged brains? Scientists at least should make an effort.

We would not criticise too severely, but surely it is all too plain that the State institutions have neither the facilities, the scientists, nor any too much incentive. The private institutions are merely places in which to care for the mentally deranged. Neither one or the other of these institutions is making, nor has the facilities with which to make, scientific study of these diseases.

Dr. Holmes is endeavoring to have our Legislature provide for a real research laboratory, maintained at one of our State institutions, for the purpose of study to overcome these insanities.

He would have this research laboratory used for the one purpose, and the research workers employed therein giving their time and energies to the one purpose.

If one-tenth of the amount of money and energy spent in the laboratories of the Depart-

ment of Agriculture was spent in a research laboratory for the prevention of insanity and cure of our insane, we venture to say that in another decade medical science would have recorded another victory, and our hospitals for the insane would not be filled. To achieve this object, of course, it will require a really scientific organization, cooperative and wholly divorced from politics. Would not the achievement of a victory over dementia praecox be worth more than all the State Hospitals of Illinois?

ABSTRACT OF MINUTES OF KANKAKEE COUNTY MEDICAL SOCIETY, MARCH TWENTIETH, NINETEEN NINETEEN.

A motion was made by Dr. A. L. Gagnon and seconded by Dr. A. N. House that the Kankakee County Medical Society pass resolutions and go on record as unanimously opposing any change in the Medical Practice Act of the State of Illinois as enacted in 1917, which is universally considered by our best authorities to be the fairest and most nearly perfect Medical Practice Act that is on the statute books of any of our states; that the Kankakee County Medical Society oppose especially such amendments as those providing for the annual registration of physicians; for the granting of the right to osteopaths to practice limited medicine and surgery without meeting the requirements established for physicians and surgeons; for the granting of special privileges or concessions to chiropractors such as those provided in a bill introduced by Representative Charles S. Stubbles of Peoria; for the lowering of the medical standards of the State of Illinois, such as House Bill No. 177 would do if enacted; for the licensing of optometrists; for compulsory health insurance, etc., and that a copy of the action taken by this medical society be forwarded to each representative from this district.

This motion was unanimously carried after having been discussed freely and vigorously without a single word being uttered in favor of any proposed amendment or any change in the Medical Practice Act of the State of Illinois as enacted in 1917.

J. T. Rooks, Sec.

TRI-CITY MEDICAL SOCIETY

At a regular meeting of the Tri-City Medical Society, held at the Hygienic Institute, La Salle,

Ill., February 24, 1919, the question of the proposed change in the laws which would require the annual registration of physicians was discussed at length, and the following resolutions were unanimously adopted:

WHEREAS, at the time of this expression there had been no definite plan for such annual registration, but rather a vague and uncertain proposition for such registration; and

WHEREAS, a more careful study of the proposed plan, after its full development disclosed the fact that it has many objectionable features; therefore, be it

Resolved, by the Tri-City Medical Society, in session at the Hygienic Institute, February 24, 1919, that it is the duty of the Medical Profession of the state to oppose the adoption of the proposed measure for the annual registration of the physicians of this state, and as a justification for such action presents the following "reasons":

First, the indorsement of the proposed plan by the House of Delegates was made before a sufficient time had been given to a consideration of all its features.

Second, because under the provisions of the act, as now presented, it is well within the powers of the Department of Registration and Education to suspend the privilege of any physician in the state to practice his profession because of a simple failure to make the proper returns within the specified time, and to place upon him the burden of proof of his right to practice his profession in the state, with all its incident costs and annoyances, including decline of practice on account of the necessary litigation which must follow in order to restore him to "good standing" in the state.

Third, the principal object of the proposed measure is declared to be the protection of the public from quackery and fraudulent practices by the unqualified; and it is unfair, unjust, and an unwarranted assault upon the rights of a profession which now stands, and has always stood for the highest principles of right and justice in dealing with the public; has always supported measures designed to better the health of the people; has never advocated any measure for the benefit of the profession only, to now demand that it shall bear the burden required by the

people to protect them from the assaults of quackery.

Fourth, it seems in order to call attention to certain facts in regard to licenses of physicians in the State of Illinois. The laws of the state require the physician to be a college graduate before entering the medical schools; to attend such medical school four years, with the addition of one year in hospital service; to take an examination before a competent board under direction of the Department of Registration and Education, whereupon, if the examination is satisfactory, a license to practice medicine and surgery in this state is granted. **THIS RIGHT IT IS NOW PROPOSED TO TAKE AWAY UPON A FAILURE TO RENEW EACH YEAR AT THE SPECIFIED TIME.**

Fifth, we do not believe that the proposed act would be any more efficient in the control of quackery than the present Medical Practice Act if rigidly enforced, and we earnestly protest against penalizing 10,000 reputable physicians in the State of Illinois in order to eliminate a few quacks who might very well be prosecuted under the present laws.

That a copy of these resolutions be sent to the senator and representatives of this district and to the County and State Medical Societies.

J. S. GREEN,
C. E. COLEMAN,
A. C. YODER,
F. J. MOCIEJEWSKI,
Committee.

LEGISLATIVE REVIEWS

We called attention in last month's JOURNAL to several proposed measures which are obnoxious to the medical profession. Some of these measures would not be difficult to defeat if a large number of doctors would get busy with their Congressmen and Senators. Naturally enough if the medical profession does not oppose an objectionable medical bill, it need not expect others to oppose it; and naturally enough the proponents of such measures are using every argument with the Legislators.

Some of the cults which are always looking for an easy road to the practice of medicine keep lobbyists in Springfield throughout the Legisla-

tive session, so we are informed. If such cults receive the aid of executive departments, the Legislators are assuredly led to believe that unopposed measures are acceptable and will support them. Legislators really are wrongly informed and are not grossly at fault if we do not look after our medical interests.

On another page we are publishing a list of the names of the Legislators and their respective districts.

The following are some of the measures now before the House which are of interest to the doctors. If any of these measures are of interest to you as a doctor, let your interest be known to your Congressmen, otherwise you have little claim upon his services.

House Bill No. 232.—For an act to regulate the practice of Chiropractic. Introduced by Mr. Stubbles.

Under this act, if passed, almost anyone, twenty-one years old, could take a course in a school of Chiropractic, such school being recognized by the Department of Registration and Education, and obtain a license to practice in Illinois. The bill among other things does not state how long such a course should be. It provides for reciprocity, thus enabling all Chiropractors to come to Illinois; and it also looks to a special examining board.

We have understood this bill is being pushed by the Department of Registration and Education. It provides for annual registration of Chiropractors, and, of course, all fines and penalties are to "inure to the Department of Registration and Education." This bill, if passed, virtually opens another gate to the practice of medicine.

House Bill No. 310.—House Bill No. 310 amends section five of the Medical Practice Act relative to the minimum standards of professional education so as to specifically provide that graduation from the Chicago Hospital College of Medicine in the year 1917-1918, shall be deemed a compliance with the requirements specified.

This, of course, is strictly class legislation. The measure probably would not affect so very many graduates, but in all probability the Supreme Court would with this amendment nullify the entire section of the Practice Act. This surely would not be desirable.

House Bill No. 353.—House bill 353 amends the Civil Administrative Code to permit laboratories to be maintained in any state institution, state normal universities, or the University of Illinois, for the purpose of research as to the cause, cure and prevention of various forms of insanity, dependency and delinquency, and mental and moral and physical defects for whose victims custody is provided by the State Department of Public Welfare. The expense of these laboratories, not to exceed two percent of the total institutional appropriations, shall be paid by the Department of Public Welfare. The work is to be carried out under a laboratory chief, appointed without regard to Civil Service.

This bill, we believe, might be all right. Undoubtedly we need more research laboratories, but the asking for funds with which to carry on medical research laboratories under the care or direction of the Department of Public Welfare should be sufficient to condemn the bill, and for this reason it should be killed.

House Bill No. 305.—An act to regulate the practice of Dentistry.

This bill was reviewed by us last month. We were told at that time that the State Dental Association was urging it. This is an error and both Dr. Moorehead, Dean of the College of Dentistry of the University of Illinois, and Dr. Dittmar, Secretary of the Legislative Committee of the State Dental Society, denounce this proposed measure. These gentlemen state that the Dental Society is framing a measure to propose, and is anxious to form one which is acceptable to the medical profession, and wishes to cooperate with the medical fraternity. Their opinion and the opinion of others is that this bill will not receive support, and while it is very objectionable there is little danger of its enactment.

House Bill No. 352.—House Bill 352 amends Section 7 of the Act creating a state colony for epileptics, providing that residents of Illinois may be admitted to the colony (a) upon voluntary application to the superintendent accompanied by certain medical certificates, etc., or (b) on application of patients, relatives, conservators, guardian or reputable citizens made to any court of record in the county in which the epileptic resides the physical condition of the individual to be determined by two or more physicians summoned by the court, and provides that

if not found to be epileptic the individual shall be released and returned to his home at the expense of the persons responsible for his admission, except that where such individuals are destitute the expenses shall be paid by the county.

House Bill No. 269.—House Bill 269 makes it unlawful for any director, or the medical staff of any public hospital to refuse to permit any duly qualified physician to treat his patient in such hospital, or to discriminate in any way against such patient or patients, provided they are able to meet their hospital expenses, such act being punishable by a fine of not less than \$100.00 or more than \$300.00, or confinement in the county jail.

If the bill were more specific and applied to City, County and State institutions, we would be in favor of the measure. We believe this is what the author intended. Others hold that the measure would apply to any general hospital, maintaining that any hospital is a public institution.

House Bill No. 174—Senate Bill No. 124.—This is the bill proposed by the Hospital Association of Illinois for the regulation of the practice of nursing.

The measure calls for a twenty-four months' course of training in a reputable training school, the applicant having completed a grammar school course or its equivalent. We reviewed this measure last month. The bill is opposing that of the Nurses' Association. Every Legislator should approve of this measure. It is squarely up to the Legislators to relieve the intolerable nursing situation, and this proposed measure will aid greatly.

House Bill No. 151—Senate Bill No. 116.—This is the bill offered by the Nurses' Association to regulate the practice of nursing.

It was reviewed last month; and is one of the most vicious bills yet proposed by nurses. We understand this bill is being modified and relieved of some of its objectionable features. Unless it is entirely rewritten and the principles reversed, the measure should be killed. It will deprive the great majority of the people from any nursing care in their families.

Senate Bill No. 296.—This is a bill to authorize Counties to levy a tax for the medical care, nursing, medicine and attendance for women

while child bearing and for children under one year of age.

This is another of those paternalistic, pauperizing measures adopted from European countries. Everyone wishes to see child bearing women cared for properly. People so mentally equipped that they are desirable citizens have no trouble in caring for their families. People not so mentally equipped are not desirable citizens and America should not breed that kind.

This and other similar measures are debasing and pauperizing in their operation, and should not be tolerated here. When and where charity is needed, give it, but do not put a premium on thriftlessness, such as this does. The bill is not one of special medical importance, but the principle involved is so un-American, so paternalistic, so pauperizing, that it should be killed, "abornin."

THE LEGISLATURE.

We are publishing below the names of the members of the legislature and the districts they represent. If the doctors will correspond with the members of the legislature freely, they will probably stop much of the proposed vicious legislation.

SENATORS AND REPRESENTATIVES FOR COUNTIES OUTSIDE OF COOK (FIFTY-FIRST GENERAL ASSEMBLY, 1919)

Adam County—Senator, Charles R. McNay, Ursa. Representatives, A. Otis Arnold, Quincy; Henry Bowers, Pittsfield; Lorand M. Wagner, Quincy.

Alexander County—Senator, Sidney B. Miller, Cairo. Representatives, Charles Curren, Mound City; J. L. Hammond, Anna; James P. Mooneyhan, Benton.

Bond County—Senator, J. G. Bardill, Hyland. Representatives, Norman G. Flagg, Moro; F. A. Garesche, Madison; Chris Rethmeier, Edwardsville.

Boone County—Senator, Rodney B. Swift, Libertyville. Representatives, Thomas E. Graham, Ingleside; James H. Vickers, Harvard; Edward D. Shurtleff, Marengo.

Brown County—Senator, Walter I. Manny, Mt. Sterling. Representatives, William H. Dietrich, Birdstown; Ben L. Smith, Pekin; Homer J. Tice, Greenview.

Bureau County—Senator, C. C. Pervier, Sheffield. Representatives, Randolph Boyd, Galva; Frank W. Morrisay, Sheffield; John W. Walters, Wyoming.

Calhoun County—(Same as Adams County.)

Carroll County—Senator, John D. Turnbaugh, Mt. Carroll. Representatives, Chas. F. Franz, Freeport;

Robert Irwin, Mt. Carroll; Joseph L. Myers, Cioto Mills.

Cass County—(Same as Brown County.)

Champaign County—Senator, Henry M. Dunlap, Savoy. Representatives, Jacob R. Drake, Lovington; Chas. A. Gregory, Lovington; William H. H. Miller, Champaign.

Christian County—Senator, Frank B. Wendling, Shelbyville. Representatives, Lincoln Bancroft, Greenup; John C. Richardson, Edinburg; Arthur Roe, Vandalia.

Clark County—Senator, John R. Hamilton, Mattoon. Representatives, E. Walter Green, Hindsboro; Robert Howard, Mattoon; A. L. Ruffner, Marshall.

Clay County—Senator, F. C. Campbell, Xenia. Representatives, A. B. Lager, Breese; C. L. McMackin, Salem; John W. Thomason, Leutsville.

Clinton County—(Same as Clay.)

Coles County—(Same as Clark.)

Crawford County—Senator, R. M. Shaw, Lawrenceville. Representatives, Rene Havill, Mt. Carmel, Samuel R. Thomas, Oblong; Jas. A. Watson, Elizabethtown.

Cumberland County—(Same as Christian.)

De Kalb County—Senator, Adam C. Cliffe, Sycamore. Representatives, Fred A. Brewer, Tampico; John P. Devine, Dixon; Albert T. Tourtillott, Dixon.

Dewitt County—Senator, William G. McCullough, Decatur. Representatives, Horace W. McDavid, Decatur; Edward C. Perkins, Lincoln; O. W. Smith, Decatur.

Douglas County—(Same as Clark.)

Du Page County—Senator, Richard J. Barr, Joliet. Representatives, Jas. R. Bentley, New Lennox; M. F. Hennebry, Wilmington; William R. McCabe, Lockport.

Edgar County—Senator, Martin B. Bailey, Danville. Representatives, William P. Holaday, Georgetown; A. L. Stanfield, Paris; Archie N. Vance, Paris.

Edwards County—(Same as Crawford.)

Effingham County—(Same as Clay.)

Fayette County—(Same as Christian.)

Ford County—Senator, William H. Wright, McLean. Representatives, George E. Dooley, LeRoy; William Noble, Gibson City; William Rowe, Saybrook.

Franklin County—(Same as Alexander.)

Fulton County—Senator, William S. Jewell, Lewistown. Representatives, A. O. Linstrum, Galesburg; M. P. Rice, Lewistown; O. B. West, Yates City.

Gallatin County—(Same as Crawford.)

Greene County—Senator, Stephen D. Canaday, Hillsboro. Representatives, A. D. Shepard, Jerseyville; Truman A. Snell, Carlinville; Otto C. Sonnenman, Carlinville.

Grundy County—Senator, Edward C. Curtis, Grant Park. Representatives, B. W. Alpin, Kankakee; Israel Dudgeon, Morris; Richard R. Meents, Ashkum.

Hamilton County—Senator, W. A. Spence, Metropolis. Representatives, Claude F. Lacy, Boaz; John J. Parish, Harrisburg; K. C. Ronalds, Eldorado.

Hancock County—Senator, Clarence F. Buck, Mon-

mouth. Representatives, James M. Pace, Macomb; Ernest O. Reaugh, Carthage; Rolo R. Robbins, Augusta.

Hardin County—(Same as Crawford County.)

Henderson County—Senator, Martin R. Carlson, Moline. Representatives, Frank E. Abbey, Biggsville; James A. Wells, Aledo; Everett L. Werts, Oquawka.

Henry County—(Same as Bureau County.)

Iroquois County—(Same as Grundy County.)

Jackson County—Senator, Frank M. Hewitt, Carbondale. Representatives, W. George Beever, Chester; James M. Etterton, Carbondale; Harry Wilson, Pinckneyville.

Jasper County—Senator, Charles L. Wood, Keens. Representatives, John Kasserman, Newton; W. B. Phillips, Mt. Vernon; Frank Vice, Jr., Olney.

Jefferson County—(Same as Jasper.)

Jersey County—(Same as Greene.)

Jo Daviess—(Same as Carroll.)

Johnson County—(Same as Hamilton County.)

Kane County—Senator, Harold C. Kessinger, Aurora. Representatives, DeGoy B. Ellis, Elgin; Fred B. Shearer, Aurora; Frank A. McCarthy, Elgin.

Kankakee County—(Same as Grundy and Iroquois.)

Kendall County—(Same as Kane.)

Knox County—(Same as Fulton.)

Lake County—(Same as Boone.)

La Salle County—Senator, Thurlow G. Essington, Streator. Representatives, Lee O'Neil Brown, Ottawa; William M. Scanlan, Peru; R. C. Soderstrom, Streator.

Lawrence County (Same as Crawford, Edwards, Gallatin, Hardin.)

Lee County—(Same as DeKalb.)

Livingston County—Senator, Simon E. Lantz, Congerville. Representatives, William H. Bentley, Pontiac; William Fahl, Toluca; Charles M. Turner, Winona.

Logan County—(Same as DeWitt.)

Macon County—(Same as DeWitt and Logan.)

Macoupin County—(Same as Greene and Jersey.)

Madison County—(Same as Bond.)

Marion County—(Same as Clay, Clinton and Effingham.)

Marshall County—(Same as Livingston.)

Mason County—(Same as Brown and Cass.)

Massac County—(Same as Hamilton and Johnson.)

McDonough County—(Same as Hancock County.)

McHenry County—(Same as Boone and Lake.)

McLean County—(Same as Ford.)

Menard County—(Same as Brown, Bass and Mason.)

Mercer County—(Same as Henderson County.)

Monroe County—(Same as Jackson County.)

Montgomery County—(Same as Greene, Jersey and McCoupin.)

Morgan County—Senator, John A. Wheeler, Springfield. Representatives, Jacob Frisch, Springfield; Clarence A. Jones, Springfield; Fred W. Wanless, Riverton.

Moultrie County—(Same as Champaign County.)

Ogle County—Senator, John A. Arwood, Stillman Valley. Representatives, Charles W. Baker, Monroe Center; Guy W. Ginders, Rockford; H. S. Hicks, Rockford.

Peoria County—Senator, John Dailey, Peoria. Representatives, Thomas N. Gorman, Peoria; Charles W. LaPorte, Peoria; Charles S. Stubbles, Peoria.

Perry County—(Same as Jackson and Monroe.)

Piatt County—(Same as Champaign and Moultrie.)

Pike County—(Same as Adams and Calhoun.)

Pope County—(Same as Hamilton, Johnson and Massac.)

Pulaski County—(Same as Alexander and Franklin.)

Putnam County (Same as Livingston and Marshall.)

Randolph County—(Same as Jackson, Monroe and Perry.)

Richland County—(Same as Jasper and Jefferson.)

Rock Island County—(Same as Henderson and Mercer.)

Saline County—(Same as Hamilton, Johnson, Massac and Pope.)

Sangamon County—(Same as Morgan County.)

Schuyler County—(Same as Brown, Cass, Mason and Menard.)

Scott County—(Same as Adams, Calhoun and Pike.)

Shelby County—(Same as Christian, Cumberland, Fayette.)

Stark County—(Same as Bureau and Henry.)

St. Clair County—Senator, R. E. Duvall, Belleville. Representatives, Frank Holten, E. St. Louis; James W. Rentchler, Belleville; Chas. F. Short, E. St. Louis.

Stephenson County—(Same as Carroll and Jo Daviess.)

Tazewell County—(Same as Brown, Cass, Mason, Menard and Schuyler.)

Union County—(Same as Alexander, Franklin, Pulaski.)

Vermilion County—(Same as Edgar County.)

Wabash County—(Same as Crawford, Edwards, Gallatin, Hardin and Lawrence.)

Warren County—(Same as Hancock and McDonough.)

Washington County—(Same as Jackson, Monroe, Perry and Randolph.)

Wayne County—(Same as Jasper, Jefferson and Richland.)

White County—(Same as Crawford, Edwards, Gallatin, Hardin, Lawrence, etc.)

Whiteside County—(Same as DeKalb and Lee.)

Will County—(Same as Du Page.)

Williamson County—(Same as Alexander, Franklin, Pulaski, Union.)

Winnebago County—(Same as Ogle.)

Woodford County—(Same as Livingston, Marshall and Putnam.)

COOK COUNTY.

1st District—Senator, Francis P. Brady, 119 E. 20th St., Chicago. Representatives, Wm. M. Brinkman,

3119 Indiana Ave., Chicago; John Griffin, 2020 Indiana Ave., Chicago; Sheadrick B. Turner, 21 E. 28th St., Chicago.

2nd District—Senator, John M. Powell, 1729 W. Madison St., Chicago. Representatives, Roger G. Marcy, 1953 W. Congress St., Chicago; Frank Ryan, 2139 W. 13th St., Chicago; Samuel E. Weinshenker, 1001 S. Ashland Blvd., Chicago.

3rd District—Senator, Samuel A. Ettelson, 3659 Michigan Ave., Chicago. Representatives, Warren B. Douglas, 3434 Calumet Ave., Chicago; Geo. Garry Noonan, 536 W. 21st St., Chicago; Adelbert H. Roberts, 3405 Calumet Ave., Chicago.

4th District—Senator, Al F. Gorman, 5426 Morgan St., Chicago. Representatives, James P. Boyle, 5448 S. Union St., Chicago; Emil O. Kowalski, 50 E. 44th St., Chicago; Frank McDermott, 1552 W. Garfield Blvd., Chicago.

5th District—Senator, Morton D. Hull, 4855 Woodlawn Ave., Chicago. Representatives, Michael L. Igoe, 5434 Cornell Ave., Chicago; Sidney Lyon, 5250 S. Michigan Ave., Chicago; Theodore K. Long, 4823 Kimbark Ave., Chicago.

6th District—Senator, James J. Barbour, 7622 Sheridan Road, Chicago. Representatives, Ralph E. Church, 1411 Chicago Ave., Evanston; Emil A. W. Johnson, 2131 Potwyn Place, Chicago; Robert E. Wilson, 4025 Greenview Ave., Chicago.

7th District—Senator, Frederick B. Roos, 512 Marengo Ave., Forest Park. Representatives, Howard P. Castle, Barrington; John W. McCarthy, Lemont; Albert F. Volz, Arlington Heights.

9th District—Senator, Patrick J. Carroll, 3533 S. Hermitage Ave., Chicago. Representatives, Thomas A. Doyle, 3549 Lowe Ave., Chicago; Joseph Placek, 2347 S. Kedzie Ave., Chicago; David E. Shanahan, 115 S. Dearborn St., Chicago.

11th District—Senator, Frank P. Sadler, 6565 Yale Ave., Chicago. Representatives, Wm. H. Cruden, 10204 Wallace St., Chicago; Edward B. Lucius, 7520 Stewart Ave., Chicago; Frank J. Ryan, 6228 Bishop St., Chicago.

13th District—Senator, Albert C. Clark, 7137 Euclid Ave., Chicago. Representatives, Gotthard A. Dahlberg, 147 E. 11th St., Chicago; James W. Ryan, 7343 Crandon Ave., Chicago; C. A. Young, 2809 E. 76th St., Chicago.

15th District—Senator, John J. Boehm, 729 W. 18th St., Chicago. Representatives, Thomas Curran, 2023 S. Racine Ave., Chicago; Joseph Perina, 1835 Fisk St., Chicago; Peter F. Smith, 1608 S. Union St., Chicago.

17th District—Senator, Edward J. Glackin, 7455 Lytle St., Chicago. Representatives, Charles Coia, 817 Forquer St., Chicago; Jacob M. Epstein, 1133 Newberry Ave., Chicago; Edward J. Smejkal, 516 Bunker St., Chicago.

19th District—Senator, John O. Denvir, 1847 S. Crawford Ave., Chicago. Representatives, James P. O'Brien, 4118 Washington Blvd., Chicago; James T. Pendergast, 1232 S. Lawndale Ave., Chicago; Solomon P. Roderick, 3310 Douglas Blvd., Chicago.

21st District—Senator, Edward J. Hughes, 3338 Ful-

ton St., Chicago. Representatives, Frederick Bippus, 4733 W. Chicago Ave., Chicago; Benjamin Mitchell, 110 S. Dearborn St., Chicago; Michael Maher, 753 N. Central Park Ave., Chicago.

23rd District—Senator, Henry W. Austin, 1022 Lake St., Oak Park. Representatives, Thomas P. Keane, 2705 Iowa St., Chicago; Edward M. Overland, 3228 Hirsch St., Chicago; Wm. G. Thon, 1227 N. Spaulding Ave., Chicago.

25th District—Senator, Daniel Herlihy, 2743 N. Albany Ave., Chicago. Representatives—Chas. L. Fieldstack, 4016 N. Hardin Ave., Chicago; John G. Jacobson, 1646 N. Irving Ave., Chicago; Theodore R. Steinert, 2112 Powell Ave., Chicago.

27th District—Senator, John Broderick, 729 W. 18th St., Chicago. Representatives, James M. Donlon, 954 W. Madison St., Chicago; Joseph Peclak, 1600 W. North Ave., Chicago; Edward Walz, 541 W. Lake St., Chicago.

29th District—Senator, Patrick J. Sullivan, 121 Maple St., Chicago. Representatives, Bernard F. Clettenberg, 1136 Orleans St., Chicago; Lawrence C. O'Brien, 1216 Dearborn Ave., Chicago; Bernard J. Conlon, 163 E. Chicago Ave., Chicago.

31st District—Senator, Willete Cornwell, 3825 Alto Vista Ter., Chicago. Representatives, Carl Mueller, 2142 Lincoln Park West, Chicago; Frank J. Seif, Jr., 1529 Orchard St., Chicago; James A. Steven, 2428 N. Clark St., Chicago.

\$100 PRIZE.

The American Association of Industrial Physicians and Surgeons offers a prize of \$100 for the best thesis on any subject related to Industrial Medicine and Surgery by any undergraduate medical student of the United States.

The thesis must not contain more than 5,000 words.

All theses must be in the hands of the secretary of the association by May 10, 1919.

DR. FRANCIS D. PATTERSON, Secretary,
Department of Labor and Industry, Third and
North Streets, Harrisburg, Pa.

THE RECLAMATION RECORD.

Major Todd Pope Ward, M. C., U. S. Army, chief of the surgical service in the base hospital at Camp Beauregard, sent us a copy of the "Reclamation Record," Vol. 1, No. 1, issued March 12, 1919, containing a description and history of the surgical service by his own pen, and an article on the Medical Service by Capt. Adrian A. Landry, chief of the Medical Service, and other features of the work by members of the staff. Lieut. Col.

J. M. Wheate is editor-in-chief of this very interesting publication, which will be a valuable means of acquainting the families and friends of the soldiers with conditions at the hospital. The surgical service has cared for 6,500 patients in its wards, including over 4,800 operative cases, with only 44 deaths, few of which could be classified as surgical deaths.

PENNSYLVANIA'S NURSING PROBLEMS

We note from the *Pennsylvania Medical Journal* that Pennsylvania has its nursing problems. A measure proposed in that state, called for a two years' college course as a qualification for entrance to a training school. This was not taken seriously, but it illustrates some of the fanatical propositions that may be "mothered" by a "nursing board."

Public Health

EPIDEMIC ENCEPHALITIS

(ENCEPHALITIS LETHARGICA—"SLEEPING SICKNESS")

STATE HEALTH AUTHORITIES MAKE IMPORTANT ANNOUNCEMENT

With the announcement by the United States Public Health Service that Encephalitis Lethargica, or, as it is improperly called "sleeping sickness," might be prevalent in portions of the United States, the Illinois Department of Public Health promulgated a special order on March 7th, making cases or suspected cases of this disease reportable to local health authorities and subject to isolation. The important provisions of this order are as follows:

REPORT OF CASES—Every known or suspected case must be reported to local health authorities within twelve hours. Local health authorities must immediately report all such cases to the State Department of Public Health.

QUARANTINE—The case and nursing attendant must be isolated. If isolation is efficient and other inmates of premises do not come in contact with the patient or attendant or with articles coming from the sick room, such other inmates may leave the premises to attend to necessary business affairs. Isolation shall continue until such time as convalescence is established and can be terminated only by local health authorities. Premises should be placarded.

REMOVALS—No case shall be removed from one premises to another or from one community to another without the permission of the local health

authorities of the community or communities affected.

SIXTY-NINE CASES IN ILLINOIS

Adams County	La Salle County
Quincy 1	Marseilles 1
Alexander County	Logan County
Cairo 1	Middletown 1
Brown County	Macoupin County
Versailles 1	Dorchester Tp. 1
Clark County	Madison County
Martinsville 1	Alton 2
Cook County	Menard County
Chicago 43	Talulla 1
Evanston 3	Richland County
Glencoe 1	Olney 1
N. Chicago 1	Rock Island County
Wilmette 2	Bowling Tp. 1
Harvey 1	Sangamon County
Ford County	Springfield 1
Paxton 1	

STATE MEDICAL STAFF INVESTIGATING

With the issuance of the order mentioned, the State Director of Public Health detailed Dr. S. S. Winner, District Health Officer of the Northeast Health District, to an investigation and study of the reported cases. Dr. Winner has seen most of the cases reported in Chicago and vicinity and has conferred with leading Chicago physicians with a view of arriving at some conclusions regarding this disease, about which little is known up to this time.

The meagreness of our present knowledge of the disease does not permit of definite conclusions, but in the interest of public safety the following precautions should be taken: (a) Reporting of all cases and suspected cases; (b) Isolation of patient and attendant, other inmates of premises not in contact with patient may be permitted to leave premises on necessary business; (c) Placarding of premises and prohibiting visitors; (d) Period of quarantine until patient is convalescent.

From the reports of further studies of and conferences on this disease the following are extracted:

EPIDEMIC ENCEPHALITIS

Definition:—A toxic, infectious, epidemic syndrome, characterized clinically by the triad—lethargy, oculian palsies and a febrile state; and anatomically by a more or less diffuse encephalitis most marked in the gray matter of the mid-brain.

Terminology:—Bassoe suggests as a more appropriate term for the disease "epidemic encephalitis."

Pathology:—Two cases in which complete necropsis were performed by Bassoe and Raulston, showing practically the same brain lesions in both cases, the gross pathology consisting of oedema, congestion and minute hemorrhages, most numerous in the brain stem, basal ganglia and centrum ovale. The microscopical pathology was similar in both cases, located in the basal ganglia and brain stem down to the upper part of the bulb. The microscopical lesions consists of dense accumulations of monocular cells around the

vessels and of small hemorrhages. There is little evidence of extensive necrosis, in contraindication of poliomyelitis. This degree of tissue destruction is also in accord with the clinical phenomena, paralysis being a much more conspicuous symptom in poliomyelitis. No organisms were found in stained sections from affected portions of the brain.

Etiology and Epidemiology:—No specific organism discovered this far. The probability of a specific virus, perhaps of the influenza type, gaining entrance through the upper air passages with a selective predilection for the mid-brain.

Predisposing Factors:—Seasonal incidence, during colder months; age, more prevalent among adults; sexes, about equally affected; excessive fatigue especially of the nervous system is a potent predisposing factor.

Mode of Transmission:—Contact, although evidence is lacking at present to substantiate this claim.

Symptoms:—Prodromata, lasting from a few days to a week, with slight catarrhal symptoms, vertigo, weakness, nausea, sometimes vomiting, intense headache and diplopia which is a fairly early symptom.

The prodromal symptoms gradually become aggravated with the patient's mind becoming clouded until a fully stuporous condition is established with very few waking moments. Short incoherent sentences may be elicited sometimes, or the patient lies absolutely passive, having an appearance of being asleep.

Nervous Symptoms:—Ptosis, which may be unilateral or bilateral. Divergence of eyes. Nystagmus, most of the observed cases showing this more marked on upward eye movement. Pupils dilated or contracted, occasionally unequal, sluggish or rigid to reaction. Facial paralysis, unilateral or bilateral. Inability to protrude tongue, which may be thickened and tremulous. Twitching of groups of muscles, especially of upper and lower extremities. Spasticity of arms and legs (catatonia). Reflexes increased mostly and aberrant. Babinski and Oppenheim found unilaterally at times and absent at other times. Kernig present occasionally, as well as ankle clonus. These are not at all constant.

Temperature may be normal or slightly above, or fluctuate from subnormal to 105 F. within a few hours.

Pulse low as compared with temperature, one case showed 35 per minute, another 50. Majority of cases about 70-90 per minute.

Urine retention found in number of cases and incontinence in a few.

Constipation marked in most cases.

Cervical rigidity, if present, not marked, the head being mobile in all directions in most cases seen.

Spinal fluid negative with exception of slight increase in number of cells.

Urine of blood negative, chemically and culturally.

Differential Diagnosis:—Poliomyelitis (1) Lethargic element largely absent, striking in epidemic encephalitis. (2) Season, encephalitis winter and spring; poliomyelitis, summer and autumn. (3) Age, encephalitis more adults. (4) Spinal fluid, negative in encephalitis;

poliomyelitis cell count running as high as 1,000. (5) Meningeal symptoms more marked in poliomyelitis. (6) Much less perivascular cell infiltration and less necrosis of brain than in poliomyelitis. (7) Leucocytes in encephalitis 8,000-9,000; in poliomyelitis 15,000-30,000 (Rockefeller Institute Findings).

The State Health authorities are of the opinion that the disease is not likely to assume anything approaching epidemic proportions, but, from observations thus far made, it is believed that a considerable number of unrecognized cases have occurred in this state as well as other portions of the country since last October. The earliest known case in Illinois developed in Chicago in November, 1918. While the mortality figures are not yet available, it is believed that the fatalities in these cases approximate 60 per cent.

HEALTH PROMOTION WEEK IN MAY

Through a Joint resolution passed by the General Assembly introduced in the House by Representative Edward J. Smejkal and in the Senate by Senator Richard J. Barr, the week beginning the second Sunday in May, for the years 1919 and 1920, has been designated as Health Promotion Week throughout the state of Illinois, and the State Department of Public Health is designated as the agency through which the programs and activities of this health week will be carried out.

The joint resolution setting forth the aims and purposes of the week, and which passed both Houses without a dissenting vote, is as follows:

"WHEREAS more than 24,000 men, women and children in the State of Illinois died of communicable diseases during the past fiscal year, and

WHEREAS more than 83,000 cases of communicable diseases were reported during the past fiscal year to the State Department of Public Health, and

WHEREAS it is conservatively estimated that in Illinois the annual cost of diseases which are communicable, and therefore preventable, is upwards of \$155,000,000, therefore

BE IT RESOLVED by the Fifty-first General Assembly, the Senate and the House of Representatives concurring, that the week beginning on the Second Sunday in May, 1919 and 1920, be hereby designated as Health Promotion Week throughout the State of Illinois, and

BE IT RESOLVED that the Fifty-first General Assembly hereby recommends to all of the people of Illinois that during the week thus designated, they shall emphasize in every possible way, the need for united action against all communicable diseases and the causes thereof, and

BE IT RESOLVED that the State Department of Public Health shall be and is hereby designated as the agency through which the programs and activities of the people during said Health Promotion Week shall be carried out."

At no time in the history of the state has the interest of the public been so centered on the subject of health promotion as it is at the present time. The accent placed upon preventable diseases by governmental

agencies during the war, and the recognition of the wide extent of preventable illness and physical defects brought out by the examination of the exemption boards, have had a lasting effect, while the terrific loss of human life and wide-spread human suffering entailed in the recent influenza epidemic have caused the people to give more serious thought to health protection and disease prevention than they ever have in the past.

It is the purpose during health promotion week to unite all the governmental and extra governmental agencies dealing with any phase of health activities and to arouse the public interest through a state-wide intensive health educational campaign. It is argued that this particular time of the year is the one best suited to such an intensive campaign, since it is the natural time for community clean-up campaigns, the most suitable period for better babies conferences, the natural time for laying the foundation for fly campaigns, and incidentally the period of the year when the roads are in excellent shape and the conditions at their best for public meetings and gatherings in rural communities.

While the plans are not entirely completed it is intended to begin the campaign on Sunday, May 11th, with an observation of Health Sunday in all of the churches in the state, and to devote each day of the following week to the purposes of the various special health activities, winding up the week on Saturday, with pageants and parades in the different communities, with educational mass meetings on Saturday night.

All of these activities will be coordinated by the State Department of Public Health, and arrangements have been made with the Illinois Tuberculosis Association to loan the services of Walter D. Thurber, Executive Secretary of that organization, to the Department as director of the state-wide program. It will be recalled that Mr. Thurber was loaned by the Illinois Tuberculosis Association to conduct the membership campaign in Illinois for the American Red Cross in 1917, at which time the Red Cross membership in the state was increased from about sixteen thousand to one million in a period of a very few weeks. Mr. Thurber's services were also loaned to the federal government in connection with the Federal War Exhibition in Chicago, much of the success of that enterprise being due to his indefatigable work.

An early number of Health News, the monthly bulletin of the State Department of Public Health, will give the complete program of Health Promotion Week, and will serve as a hand book for local communities.

Conferences are now being called with the officers of civic, social, industrial, commercial and health organizations for the purpose of making the observation of Health Promotion Week uniform in every section of the state and among all classes of people.

EDUCATIONAL CAMPAIGNS IN VENEREAL DISEASES

The Division of Social Hygiene of the State Department of Public Health is conducting an active

educational campaign throughout the state. Four physicians are engaged constantly in Chicago, giving daily talks to men employed in industrial plants. These meetings occupy thirty minutes, fifteen minutes being granted by the employer and fifteen minutes given by the men themselves.

Dr. Rachell S. Yarros is engaged in a speaking trip throughout the state, including East St. Louis, Alton, Springfield, Jacksonville, Decatur, Champaign, Peoria, Eureka and Joliet. Dr. Yarros confines her educational work to women, giving three lectures a day, one to mothers, one to school girls, and an open evening meeting designed especially for working girls and women.

Dr. Hugh T. Morrison of Springfield, recently discharged from military service, is taking part in this educational campaign, speaking at Springfield, Mt. Pulaski and other points.

Dr. G. G. Taylor, chief of the Division, spoke recently before the Kewanis Club at Peoria, the Rotary Club of Bloomington and the City Club of Chicago. Social Hygiene Committees, for the purpose of aiding in the campaign against venereal diseases, have been organized by the Rotary Clubs of Rock Island, Champaign, Chicago, Bloomington and Decatur and by the Kewanis Club at Peoria. The City Club of Chicago has created a similar committee.

NEW POLIOMYELITIS CLINICS

The Division of Child Welfare and Public Health Nursing of the State Department of Public Health announces the establishment of clinics for crippled children, especially designed for victims of poliomyelitis, at Monticello, Piatt county, and at Streator, LaSalle County. With the clinic opened during the month at Freeport, Stephenson county, there are now sixteen clinics for crippled children under the direction of the State Department of Public Health, regularly in operation throughout the state.

In every community where a clinic is established, funds are raised either through public or private subscription for the purchase of braces and deformity apparatus, and provision is also made, locally, for the follow-up work and nursing instructors of the dispensary patients. Two graduate nurses in the employ of the State Department of Public Health, travel constantly arranging for clinics and supervising the follow-up work.

At the new clinic at Freeport, opened during the month, fifty-four patients were examined, these patients coming from the counties of Carroll, Stephenson and Jo Davies. A large number of physicians from these counties were also present.

VENEREAL DISEASE CLINICS

Some misunderstanding on the part of the medical profession has been brought about by the misconception of the purposes and methods of the Division of Social Hygiene of the State Department of Public Health, working in cooperation with the United States Public Health Service in the establishment of local

clinics or dispensaries for the diagnosis and treatment of venereal diseases, and similar misconception seems to have arisen out of the announcement of the Division of Diagnostic Laboratories that Wassermann tests for syphilis are being made without charge, regardless of the financial condition of the patient.

As a matter of fact, no clinic or dispensary is established in any community without thorough cooperation with the local city or county medical society, and no plans are made for such clinics excepting where the need for their establishment is thoroughly recognized by local physicians. In this way, the interests of the local medical profession are in every way safeguarded.

While the diagnostic laboratories at Springfield are conducting Wassermann tests without charge, as it has done for many years in examinations made for the diagnosis of tuberculosis, diphtheria, typhoid fever and other communicable diseases, specimens are not received from the individual patient, but must be transmitted to the laboratory by the attending physician. In this way, the determination of the extent to which such free service is given is left in the hands of the medical profession. With this rule strictly enforced, it is interesting to note the great increase in the number of specimens received by the laboratory for the diagnosis of syphilis, indicating that the physicians themselves are thoroughly appreciative of the free services rendered, and desire to utilize it to a constantly growing extent.

In practically every community in which state and federal programs against venereal diseases are being carried out, the local medical profession is proving thoroughly sympathetic with the work and it is significant that in every case where a representative of the Division has had the opportunity to properly explain the program to local medical societies, criticisms and opposition have been immediately withdrawn. It is the conviction of the Department of Public Health that such little criticism as there has been, has been due entirely to a misconception of the plans and methods of the division and not to any real fault in the program.

Editor's Note.—In the March number of the JOURNAL we criticised the State Department of Health for its free venereal clinics and advertising free Wassermann tests.

The explanation, we think, is no better than the plan. Why on earth should we place a premium on venereal disease by treating those patients free? Why should the State of Illinois give free Wassermanns and thus rob the ethical, efficient laboratories of those fees?

This is in no way comparable with the free work done in tuberculosis, diphtheria and other diseases contracted by people through no fault of their own.

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It would be interesting to know what explanation the Department could give for the making of a free Wassermann and the treatment of syphilis in a person of means at the expense of the State and the loss of business to other physicians and laboratories. We would also like to know just how many local medical societies are officially cooperating in establishing free clinics and free laboratories.

Correspondence

A RESEARCH INSTITUTION FOR ILLINOIS

Chicago, April 5, 1919.

To the Editor: I herewith enclose copy of letter sent to his Excellency, Governor Frank O. Lowden. The purpose is to advance medical science by means of co-operation in all lines of medical research and endeavor. This scheme as here outlined seeks to lay a plan whereby there would be complete unification and co-operation of the professional learning with the educational and hospital departments in the State.

If you think favorably of what is here set down, I would thank you for your comment. If you have criticism, I hope you will express it, that the plan may thereby be improved.

Most respectfully yours,

J. RAWSON PENNINGTON.

March 27, 1919.

SUBJECT: ILLINOIS FOUNDATION FOR RESEARCH, MEDICAL EDUCATION AND SANITATION

My dear Governor: The late war has shown us our limitations, possibilities and the benefits that can result from higher medical organization. Why should not Illinois pick up the golden thread and organize the intensive work already begun? Such a step would put Illinois into the front rank as a medical center, and might lead to a nation-wide foundation along similar lines.

In the beginning of the war every wound was potentially dangerous on account of infection. In this hour of crying need Alexis Carrel of the Rockefeller Institute and H. D. Dakin, New York, arrived on the battle-front and conquered

infection in suppurating wounds before the end of the first year of the war—the greatest achievement in medicine since vaccination; and an achievement which saved thousands of lives and tens of thousands of limbs.

General Gorgas, through commissions of army surgeons in the various cantonments, accomplished as brilliant results in the treatment of empyema, (pus in the lung sac).

These extraordinary achievements and many others that could be mentioned show the great value of combination work in medicine and surgery. There are innumerable other diseases which can be conquered in like fashion by organizing and systematizing the clinical material, the hospitals, the schools, etc., that we already have into a comprehensive research, medical and sanitary institution—an institution consisting of the accredited under-graduate medical schools of the state, a graduate medical school, the state and county hospitals, and other institutions for the care of the sick, a department of sanitation, and a research laboratory—giving the full equipment, and more, that was at the disposal of Carrel and Gorgas.

The state, county and other hospitals should be organized into a state hospital organization, maintaining reciprocal relations with each other. The management of the resources of the individual hospitals to remain under local direction; but the scientific and clinical work should be under state control for scientific purposes and for the further purpose of the diffusion of higher medical knowledge. I might also state in this connection that it is universally conceded that the teaching hospital is the best for the patient, the doctor, and the people.

This medical organization should include a department of rural and city sanitation also.

The state should appropriate sufficient funds to found a medical research laboratory, placing it in charge of a competent director, whose professional attainments, fitness and skill are unexcelled.

This done, the state of Illinois will have, at a comparatively small outlay, the most comprehensive Foundation for research, medical education, and sanitation in the world.

I offer these suggestions, my dear Governor, with the full knowledge that higher medical education and the unsolved medical problems can best be accomplished by combinations and

co-operations, as has been demonstrated within the last four years.

If you, as Governor, could materially advance the cause of medicine and surgery, as I believe the above plan would do, you would be conferring the highest and a most lasting benefit on mankind—a benefit that is the highest ambition to which a man can aspire.

Most respectfully submitted,

J. RAWSON PENNINGTON.

Governor Frank O. Lowden,
Springfield, Illinois.

Editor's Note.—The late Senator J. J. Ingalls in "Opportunity" said, "I knock unbidden once at every gate." It would seem to us that this is the time—the opportunity—to make Illinois the medical center of the world. "It is the hour of fate."

The European war, we believe, has decreed that for the future the medical world will not revolve around Vienna. With the wealth of clinical material in the Cook County Hospital and in the various State institutions, and the teaching facilities that could be offered together with a great research laboratory affording access to the medical profession, certainly it is not a far step to the realization of the above proposal. Now is the time to accept the opportunity.

MR. SHEPARDSON AND BOLSHEVISM.

To the Editor.—Section 22 of Mr. Shepardson's proposed amendments to the Medical Practice Act, ILLINOIS MEDICAL JOURNAL, March, 1919, page 158, reads:

"In every proceeding under the provisions of this act an averment that the defendant at the time of the alleged defense was without the required license or certificate of renewal of registration shall be taken as true, unless disproved by the defendant." This is certainly Bolshevism in action. Mr. Shepardson wishes to legalize himself into the position of judge, jury, prosecuting attorney and hangman. Indeed, shall we not ask with the dramatist, "Now, in the names of all the gods at once, upon what meat does this our Cæsar feed that he has grown so great?"

Mr. Shepardson seeks to set aside all the rules of law and justice "that a man is presumed to be innocent until proven guilty. Yet under the

wording of Section 22, namely, a mere averment or statement that a physician has committed a misdemeanor makes it incumbent upon the doctor to disprove the verdict of guilty on the mere averment by the department.

Civilization is not strong enough to dispense with any of its safeguards. Bolshevism is something the governing elements of America do not want and the best way to insure against its development is to seek out and remove those grievances which rankle and embitter and which create a receptive mood for such propaganda. Measures of repression will not avail. The exercise of arbitrary power from the beginning of time has been the source more than the cure of violence and disorder. It was that which gave being to Bolshevism in Russia.

A determined minority with a grievance is a dangerous proposition in these days. Its power is only a matter of organization. The wise motto to adopt, therefore, is: 100 per cent justice for every man.

The language used in Section 7 of the proposed amendment of the Medical Practice Act (ILLINOIS MEDICAL JOURNAL, March, 1919, page 156), together with the arbitrary attitude assumed by the Director of Registration for the control of hospitals, nurses and the attempt to foist annual registration upon physicians (the latter a measure if of any value whatever is purely in the interest of the people who should pay for it and not the physicians) and other manifestations on the part of the director to arbitrarily control everything and anybody shows clearly on the part of Mr. Shepardson a disposition to be dictator of medical colleges, hospitals, training schools and the entire educational system of Illinois.

This is a power and influence never contemplated or dreamed of when the consolidation act was legalized. Such centralization of power is too dangerous to be tolerated in a free state and to give one man control of our educational system amounts to neither more or less than a legalized despotism.

An old time king of France, when asked what tax he collected from certain cities of his realm, answered: "What I please." Governor Lowden (unconsciously, of course) in creating the office of Director of Registration seems to have brought about a similar autocracy.

This drift toward autocracy in the Department of Registration and Education will not do. Illinois is still a free community with no hankering to put itself in the hands of a benevolent despot. The centralization of power which the governor allowed to be placed in the hands of the department of registration and education is too great. It must not be continued.

Autocratic control was the plan of Bismarck, who said in substance: "That if Berlin could plan the schools, he did not fear for the permanency of his policy." In a government like ours, completely dependent upon an alert, educated electorate, institutions so founded and ruled that they cannot be used for purposes of political propaganda, are fully as necessary as a free press and the right, within the limits imposed by justice, charity and common sense, of free speech upon any subject. The medical profession of Illinois has lost confidence in the Board of Registration and Education. In the interest of harmony and efficiency, there is only one solution of the problem, that is to take the departments that have to do with medical matters, such as licensure, hospital standardization and control and training schools, away from the Department of Education and place them as a bureau in the State Department of Health, where they legitimately belong, and where it was originally intended they should be.

C. J. WHALEN.

SOME GEM

Equality, Ill., February 13, 1919.

To the Editor.—I send you a gem of newspaper surgery, clipped from the *Evansville Courier* of recent date.

Such a jewel as this should not be lost in the shuffle and I hope you will have space to immortalize it.

L. W. GORDON.

MURPHY BUTTON FOUND IN ABDOMEN.

LOCAL MAN'S DEATH DUE TO LOOSENING OF CONNECTION PLACED IN FIRST OPERATION.

Elmer L. Lindley, a shoe repairer, 703 Mary street, succumbed to a complication of diseases early yesterday. A year ago Lindley submitted to an operation. Following it he suffered frequent spells of illness, during which he complained of severe abdominal pains. They were followed by vomiting, which brought relief.

Drs. Long and Heberer were called into consultation two months ago. They performed a second operation and found a "Murphy Button" in his abdomen, left there by the first physician.

The button had been used to form a connection between the abdomen and intestines. Originally it had been silver but acid had turned it to brass.

After sewed up in the man the button clogged the passage into the intestines. Vomiting removed it.

The deceased was 47 years old and was widely known. He leaves a wife, Stella; three children, Amelia, Ralph and Louis; a mother, Mrs. Scinira, of Cates, Ind.; two brothers and two sisters.

Society Proceedings

ADAMS COUNTY

The Adams County Medical Society held their regular meeting Monday, March 10, 1919. In the absence of the president, meeting was called to order by first vice-president, Dr. H. P. Beirne. Outside of the society business, the most important matters discussed were the various House Bills. Secretary read abstract of Nursing Bills before the general assembly and communications from Illinois Hospital Association.

It was moved, seconded and carried that the Adams County Medical Society endorse the People's Bill, as endorsed by the Chicago Medical Society. The following resolution was introduced by Dr. L. H. A. Nickerson and adopted by the unanimous action of the society:

WHEREAS, The Medical Profession has always worked in the interest of the public, we do not ask any special favors and believe in treating all alike. We are opposed to granting any special favors to any paths or sects. Our slogan is "Let all pass the same requirements."

Resolved, The Adams County Medical Society now assembled are opposed to any bill or amendments that lower the present Medical Practice Act, which act enjoys the distinction of being the fairest and the best medical practice act—that is on the statute books of any state. We are opposed to the proposed amendment to provide for annual registration of physicians. We are opposed to granting Osteopaths to practice limited medicine and surgery without meeting the present requirements for physicians and surgeons. We are opposed to licensing of Chiropractors who are notoriously known as being deficient in the preliminary education.

We are opposed to bills 177 and 80. We are also opposed to general principle to any bill which tends to lower the standard of the present Medical Practice Act.

ELIZABETH B. BALL, Secretary.

COLES-CUMBERLAND COUNTY

At the meeting of March 11, 1919, the following resolutions were adopted.

WHEREAS, a bill has been introduced into the Legislature of the State of Illinois, by the terms of which

the physicians and the requirements of the State of Illinois, for the practice of medicine and surgery, and those who will hereafter apply for license to practice medicine and surgery in the State of Illinois, will have to pay an annual license and be subjected to the necessity of obtaining, each year, a license to practice medicine and surgery in the State of Illinois; and

WHEREAS, the present law of the State of Illinois requires that an applicant for a license to practice medicine in this State shall be of good moral character and shall be a graduate of some reputable and recognized school of medicine requiring four (4) years' medical study, and that the applicant have, in addition, one (1) year of hospital service; and

WHEREAS, under the present law, if any member of the medical profession, having a license to practice medicine in the State of Illinois, is guilty of improper practices, or violates the law, proceedings can be had against such member of the profession and he can be dealt with accordingly; and

WHEREAS, these present requirements certainly contain and are a guaranty of sufficient mental ability, training, education, energy, morality and mental attainments; and

WHEREAS, to add to these requirements the necessity of obtaining a license each year, places all of the members of this most useful profession on the level with the few lawbreakers in that profession and puts all of the members of the profession, irrespective of their character, on the defensive and under suspicion; and

WHEREAS, to pass this law would place this honored profession on the level with the trades and would not only injure the security and dignity of the members thereof, but would hamper their usefulness, and would bring about no good to anyone, but would bring harm to the members of the profession; and

WHEREAS, it would be most unfair and unjust to subject the members of this profession to this requirement and to subject them to the change each year in the personnel of the Board having charge of the issuance of such license; and

WHEREAS, the adoption of the said law would make it possible to favor some particular cult and injure others, therefore, be it

Resolved, by the Coles-Cumberland Medical Society, in convention assembled, that this Society and the members thereof, take all steps possible to prevent the enactment of this bill as a law; and, be it further

Resolved, that the members of this Society get in touch with all of the Senators and the members of the House of Representatives that they know and present the matter to them, to the end that they may be made acquainted with the evils attending the enactment of this bill as a law; and, be it further

Resolved, that a copy of this resolution be sent to the Senator and Representatives from this District and to any and all other persons who should be

advised as to the feeling of the members of this Society.

R. J. COULTAS,
C. E. MORGAN,
W. R. RHODES,

Committee.

Approved March 11, 1919.

C. H. HARWOOD,
President.

R. H. CRAIG,
Secretary.

WHEREAS, a bill has been introduced into the Legislature of the State of Illinois to license Chiropractors without requiring a preliminary education and without requiring a sufficient knowledge of the Sciences essential for the treatment of Human ailments; and

WHEREAS, a bill—House Bill No. 177—has been introduced which reduces the requirements and lowers the standard of the medical education; therefore, be it

Resolved, by the Coles-Cumberland Medical Society, in convention assembled, that this Society and the members thereof take all steps possible to prevent the enactment of these bills as laws; and, be it further

Resolved, that this Society approves of the Medical practice law as now enacted and on the statute books; and, be it further

Resolved, that this Society is opposed to any Cult or Health Creed being licensed by the Legislature of the State of Illinois at a lower standard than that required of the Profession of Medicine and Surgery; and be it further

Resolved, that this Society is opposed to lowering the standard of Medical Education in Illinois; a standard recognized by many States; a standard safe for Public Welfare.

COOK COUNTY

CHICAGO MEDICAL SOCIETY

Meeting, March 5, 1919.

Amalgamation of Public Health Activities—Fred. J. Taussig, St. Louis, Mo.

Discussion—C. St. Clair Drake, Springfield, Ill.; John Ritter, E. V. L. Brown, and Chas. J. Whalen.

Meeting, March 12, 1919.

1. Vital Energy and Surviving of Heart with Cinematograph—Prof. Dr. Octave Laurent, Surgeon of the Military Hospital, Grand Palais of Paris, France.

2. The Importance of the Anerobic Bacteria to Man—W. L. Holman, University of Pittsburgh, Pittsburgh, Pa.

Meeting, March 19, 1919.

1. Epidemic Encephalitis. Historical Review. Clinical and Pathological Features, with Report of Cases—Peter Bassoe.

Discussion—Chas. A. Elliott, Fred. Tice and Hugh T. Patrick.

2. Some Hernia Problems—Weller VanHook.

Meeting, March 26, 1919.

1. Influenza in Private Practice—Edward F. Wells.

2. The Nostrum and the Public Health. Illustrated with Lantern Slides—Arthur J. Cramp, Director of Propaganda for Reform Department, Journal A. M. A.

3. The Council of Pharmacy and Chemistry—Present—Future—W. A. Puckner, Secretary Council on Pharmacy and Chemistry.

Discussion—James B. Herrick.

Meeting, April 2, 1919.

1. Tuberculin Treatment of Tuberculosis in Children—Ernest Lackner.

Discussion—Ethan Allen Gray.

2. A Glance at Some of the Old and New Theories on the Causation of Cancer—J. Rawson Pennington.

Discussion—Chas. J. Drucek.

CHICAGO OPHTHALMOLOGICAL SOCIETY.

A regular meeting was held November 18, 1918, with the president, Dr. Heman H. Brown, in the chair.

SUPERFICIAL PUNCTATE KERATITIS

Dr. Michael Goldenburg presented a case of Superficial Punctate Keratitis in a girl unmarried, age 25, bookkeeper, who first came under his observation August 30, 1916.

Previous personal history: Has always been in perfect health except occasional symptoms of flatulency, and the eye trouble, which started about six months ago. She does not know how this started, or what brought it on. She complained of pain in the eyes, sometimes very severe, photophobia, profuse lachrymation, and at times marked disturbances of vision so that she cannot work. Her vision at that time was, right 15/50; left 15/80. Upon examination we found slight circumcorneal injection, conjunctival sacs filled with tears, pupils equal and regular and react well to light and accommodation. With oblique illumination one could see many small grayish elevations about 1 or 2mm in diameter scattered over the cornea. With the Coddington lens we found in addition to these little elevations many small grayish dots of about the same size that were perfectly flush with the normal cornea. The epithelium throughout was intact, retained its luster and did not stain. At no time has there been a tendency for these dots or elevations to join others and form larger ones as we sometimes see in bullous keratitis.

This case has now been under my observation for over two years. I have seen these little elevations which come in crops, always attended with pain of more or less intensity, disappear in five to ten days, leaving behind these little grayish dots and in another five or ten days they in turn disappear, leaving no recognizable sign of their previous presence. The crops at times come and go before the previous ones have entirely cleared up. At times there may be so many present that one cannot count them, and again

there may be only four or five visible; they may appear in one or both eyes and at times alternately. For the past year she has been able to tell a few days in advance when a new crop was about to appear.

The disturbance of vision is entirely dependent upon whether these dots or elevations are in the pupillary area and the amount of lachrymation present. It is my belief that the pain is due to the formation of these little elevations, by which I mean that a fluid or cellular infiltrate appears anterior to Bowman's membrane, forcing forward the superficial epithelium, thus producing traction upon the delicate nerve filaments or corneal end-organs, for as soon as these elevations have reached the maximum height the pain ceases and only the sense of roughness remains.

Every clinical examination and laboratory test has been made by competent internists, radiologists, rhinologists and odontologists and all have reported a negative finding. Every form of treatment known or suggested has been tried, i. e., rest by atropine, bandaging, bichloride, and atropine ointment, subconjunctival injections, dietetic, starvation, deep intra-muscular injection of cachydylate of sodium, etc., but still these crops come and go. It is interesting to report that for the first seven or ten days that a new form of treatment is resorted to she would show improvement, then she would drop back again. She has during all this time also been under the care of a thoroughly competent internist.

Her vision with a small minus correction can be improved to 15/20 in either eye when cornea is sufficiently clear.

My object in presenting this case is not its rarity, but its stubborn response to treatment, in the hope that some one may cast some light on the apparent obscure etiology of this case and thus aid in its treatment.

DISCUSSION

Dr. Tydings asked if it took the flourescein stain.

Dr. Goldenburg said no. In superficial punctate keratitis it never stained. In herpetic keratitis you will have some staining; that is a point of differentiation.

Dr. Tydings suggests that we eliminate every possible source, particularly sinuses or tonsils. Point of differential diagnosis between superficial punctate keratitis and herpetic keratitis. Exactly the point he wanted to bring out. Will find that in case of sinus trouble may have blebs come on fingers or back of hands. Wherever you have septic conditions you will almost always find trouble in sinuses or tonsils.

SPONTANEOUS HEMORRHAGE INTO THE VITREOUS

Dr. H. W. Woodruff presented a case of spontaneous hemorrhage into the vitreous. The patient, Gus Vervinck, age 20 years, came to the Illinois Charitable Eye and Ear Infirmary, April 28, 1918. He claimed to have lifted about 500 pounds and about two hours after was unable to see. Vision right eye, could count fingers at one foot; left eye, 15/200. Blood pressure systolic 110. Diastolic 80. Urine analysis negative. Wasserman negative. Tubercular test negative.

(Continued on page 221)

FORD-IROQUOIS COUNTY

At the annual meeting of the Ford-Iroquois Medical Society, March 4th, the following officers were elected:

Lester C. Diddy, Piper City, president; F. W. Buckner, Watseka, vice-president; W. L. Cottingham, Paxton, secretary-treasurer; W. E. Burgett, Onarga, censor; N. T. Stevens, Clifton, delegate; E. E. Hester, Paxton, alternate.

By unanimous vote of the society, opposition to house bills 80 and 177, to amend medical practice act for licensing physicians and bill for licensing chiropractors, as introduced by Stan Stubbles of Peoria, was recorded.

W. L. COTTINGHAM, Sec.

FULTON COUNTY

Special Meeting.

Eighty-fifth Meeting.

The Eighty-fifth meeting of the Fulton County Medical Society was held in the parlors of the Y. M. C. A. at Clinton, Ill., March 29, and was called to order at 2 o'clock p. m. by President Oren.

The Secretary called attention to several bills now pending before the State Legislature inimical to public health that should have the decided opposition of the Medical Profession.

Coleman and Chapin moved that the President and Secretary be empowered to act for the Society and conduct the campaign against these bills. Carried.

Shallenberger and Nelson moved that the Secretary write Senator Jewell commending him for his decided stand against these bills. Carried.

J. M. Nellis and J. P. Long were elected to membership.

Coleman and Smith moved that the Secretary write Surgeon General Blue advising him of the proposed Bill compelling hospitals and sanatorium to admit all patients regardless of whether or not they were suffering infectious or obnoxious diseases that would endanger other patients, and thereby menace public health. Carried.

Dr. Charles J. Drueck of Chicago gave a very interesting and instructive paper on "Rectal Surgery Under Local Anesthesia."

Lieutenants Long and Boynton gave equally important impromptu talks on their "Experience in Army Hospitals Within the United States."

One very important point emphasized by Lieut. Long was that concussion from bursting shells had very little if anything to do with producing so-called "shell shock." Hundreds of patients with this condition came under his observation who had not been within fifty miles of the fighting line.

This peculiar nervous and mental condition the etiology and pathology of which has not been satisfactorily determined is placed on the Army records as a psycho-neurosis.

A unanimous vote of thanks was given Lieuts. Long and Boynton and Dr. Drueck.

Thirteen members were present.

McLEAN COUNTY

The McLean County Medical Society held the annual scientific all day meeting in Bloomington, Feb. 28. The forenoon was devoted to clinics. A surgical clinic by local physicians was held at Brokaw Hospital from 8:30 to 10. A goiter clinic was held at St. Joseph Hospital and one case was operated on at 8 a. m. A clinic in the diagnosis of abdominal diseases was held commencing at 9 o'clock by Dr. F. Buckmaster of Effingham. Dr. Rufin Abbott of Springfield held a clinic on tubercular diseases and demonstration of types of cases from 11 to 1.

The physicians of Bloomington provided a luncheon at the Woman's Exchange for the visiting doctors and their ladies. At 2 o'clock the scientific session was called to order and the following program given and discussed.

Meeting for Addresss and Discussion

1. Blastomycosis, Exhibition of a Case. Dr. E. E. Perisho, Streator.

2. The Tri-State Medical Society, Dr. Wm. B. Peck, Freeport.

3. Subinvolution of the Uterus and Chronic Metritis. D. F. Buckmaster.

4. Later Phases of Radium Therapy. Dr. Chas. W. Hanford, Chicago.

5. Short Talks by Returned Army Officers. Dr. O. J. Sloan, Dr. L. B. Cavins, Dr. Frank Deneen, Dr. F. W. Brian.

Dr. Montgomery of Lincoln, and Dr. Burke of Atlanta, gave impromptu addresses.

PEORIA CITY MEDICAL SOCIETY

The officers of Peoria City Medical Society are as follows:

Dr. Roland Lester Green, president; Dr. E. E. Gelder, first vice-president, Dr. John F. Sloan, second vice-president; Dr. A. J. Blickenstaff, secretary-treasurer; Drs. E. L. Davis, W. B. Wakefield and George Mitchell, board of censors; Drs. T. W. Gillespie and O. B. Will, delegates to State society; Drs. E. E. Gelder and E. E. Barbour, alternates; Dr. W. B. Eicher, legislative committee.

A. J. BLICKENSTAFF, Sec.-Treas.

ST. CLAIR COUNTY

The St. Clair County Medical Society met in regular session at 8 o'clock p. m., March 6, with twenty-five members present, and as guests of the Society, President E. W. Fiegenbaum, of Edwardsville; G. G. Taylor, Chief of the Division of Social Hygiene, of Department of Public Health, Springfield, and B. M. Bolton, of St. Louis.

Dr. Charles Louis Tegtmeier, of Millstadt, was elected to membership.

State President Dr. E. W. Fiegenbaum, of Edwardsville, addressed the Society on the subject of

"Organization," laying great stress on the necessity for a more active membership if we are to be permitted to continue in the unmolested practice of our profession, and emphasized the extreme importance of a better attendance at the meetings of the County Societies, and the manifestation of a more active participation in the actual work to be accomplished outside the scientific program. The apparent indifference of many prominent members in matters of the most vital importance to the profession was condemned in the strongest terms. This inactivity was compared with that of the "parasite" classes in pending legislative matters, with the balance in favor of the latter in its appeals to the members of the legislature, both in "lobby" work and in appeals by letter. The perils of "annual registration," "compulsory health insurance," "limitation of nursing the sick," "invasion of the medical field, under authority of the state licensing body by more of the parasitic classes," were some of the features demanding the greatest activity in the regular profession.

The address was received with great enthusiasm by the members present, and will prove an inspiration to greater effort on their part, and to a closer watch upon the character of representatives from the county.

A free discussion was given by the members. Dr. Royal Tharp, late a Captain in the Medical Officers' Reserve Corps, spoke on the conditions prevailing among the doctors in Great Britain under the Compulsory Health Insurance, his remarks being based upon a personal knowledge gained while convalescing in Scotland after being "gassed" in France; and his observations are convincing. Dr. Tharp is of the opinion that in five years we will be in the same conditions as our professional brothers in England. And we will, unless we form a "more perfect union" and secure the support of every doctor in our efforts to repel any encroachments upon our rights.

Dr. Taylor spoke on the work of his department in the protection of the innocent from the dangers of venereal disease, and defended the "free clinic" idea.

Dr. McNary, chairman of the Legislative Committee, reported upon the work of his committee, and advised a more earnest support of the Committee by the members.

Dr. Campbell, chairman of the Public Policy Committee, reported some progress in outlining a program for great efficiency in the Society as a factor in county affairs.

Society adjourned.

C. W. LILLIE, Secretary.

WILLIAMSON COUNTY

Your letter received today. The Williamson County Medical Society met in Marion, March 13, and elected the following officers: president, Dallas S. Boles, Herrin; vice-president, Edward E. Woodside, Marion; secretary-treasurer, Joseph G. Parmley, Marion; delegate to state meeting, J. G. Parmley, Marion; alternate to state meeting, John W. Vick, Cartersville; legisla-

tive committee, Drs. A. M. Edwards, Levi B. Casey and Dr. Parmley, all of Marion.

J. G. PARMLEY, M. D., Secretary.

Personals

Andrew J. Lyons, Major, M. C., U. S. Army, has returned from abroad.

Dr. C. H. Eldridge has moved from Frankfort Heights to West Frankfort.

Hugh T. Morrison, Captain M. C., U. S. Army, has returned to Springfield.

Dr. O. W. Allison of Catlin has returned from a winter at Palm Beach, Fla.

Dr. and Mrs. Winfield S. Dixon, of Metropolis, have returned from a trip South.

Dr. George P. Gill has returned from service and resumed practice in Rockford.

Frederick A. Besley, Lieutenant-Colonel, M. C., U. S. Army, has returned from California.

Dr. Henry B. Downs, physician and attorney, has removed from Danville to Kilgore, Nebraska.

Arthur L. Sprenger, Lieutenant-Colonel, M. C., U. S. Army, returned to Peoria from France last month.

Robert Nelson Lane, Captain, M. C., U. S. Army, Gibson City, returned from overseas, March 5.

David S. Hillis, Lieutenant-Commander, M. C. U. S. N. R. F., has returned from service in the Navy.

Elden M. Price, Lieutenant, M. C., U. S. Army, has been released from military service and returned to Astoria.

John Edward Kelley, Captain, M. C., U. S. Army, who has been on duty in France, has returned to Chicago.

James J. McGinnis has returned after six months' work with the American Red Cross in France and Germany.

Eugene Cary, Captain, U. S. Army, who has been on duty with the Royal Air Forces, has returned to this country.

Dr. Joseph Zeisler of Chicago gave a clinical lecture on diseases of the skin at the University of Michigan on March 12.

Joseph A. Capps, Lieutenant-Colonel, M. C., and Ray H. Davies, Major, M. C., U. S. Army, have returned from abroad.

Dr. E. J. Brown, of Decatur, who has been spending the winter in Los Angeles, has returned and resumed practice.

Dr. Joseph D. Lundholm, after more than a year's service at Camp Grant has returned to Rockford and resumed practice.

R. Boyd Andrews, Lieutenant, M. C., U. S. Army, was released from military service and returned to Belvidere last month.

Dr. J. Allen Cotton, Peoria, was shot and seriously wounded by a sergeant of the Eighth Illinois Infantry, at Peoria, March 9.

Dr. Homer F. Moore, First Lieutenant, M. C. U. S. Army, after service with Base Hospital 119 in France, has returned to Rockford.

Dwight F. Morton, Capt., M. C., U. S. Army, has been promoted to the rank of major while with the Ottis Hospital unit in England.

Selim W. McArthur, Captain, M. C., U. S. Army, formerly connected with Base Hospital Unit No. 14, has been ordered to Coblenz, Germany.

Harry E. Mock, Lieutenant-Colonel, U. S. Army, will attend the Interallied Reconstruction Congress at Rome in May, as an American delegate.

Dr. William O. Krohn announces his return to Chicago after service in the Medical Corps, U. S. Army, resuming practice at 29 East Madison Street.

John Wesley Tope, Captain, M. C., U. S. Army, Oak Park, who went overseas with the Thirteenth Engineers, returned to the United States, March 5.

Luther B. Highsmith, Lieutenant, M. C., U. S. Army, Flat Rock, returned with the officers of Base Hospital No. 22 from abroad and reached Camp Grant, March 12.

Maurice L. Goodkind, Major, M. C., U. S. Army, who is on duty in France with the Fifty-Third Hospital Unit, has been promoted to the rank of lieutenant-colonel.

Dr. Ralph H. Kuhns, recently Captain, M. C., U. S. Army, after three years service, including

eight months in the war zone, announces his return to practice in Chicago.

Dr. Anton Mueller has been appointed commandant of a sanitary training detachment in the service of the American National Red Cross, ranking as such from February 20, 1919.

Herbert H. Frothingham, Major, M. C., U. S. Army, who has been on duty at Fort Des Moines as chief of the medical service for more than a year, has returned to Chicago and resumed practice.

The rumor that Dr. Samuel J. Walker of Chicago died of typhus fever while with the American Red Cross mission to Greece has been denied by the American Commissioner to the Balkan States.

Dr. A. G. Kessler, who has been assisting Dr. C. M. Jack, of Decatur, the past two months, has been chosen superintendent and medical director of a tuberculosis sanatorium at Crookston Minn.

Dr. Max Thorek, of Chicago, was guest of honor at an elaborate birthday reception and dinner, March 10, at Hotel Sherman. Among the speakers were Judges Goodnow, McGoorty and Sabath.

Walter J. Sullivan, Lieutenant, M. C., U. S. Army, who was severely wounded last May, after four months in a hospital in London was returned to Marseilles, and has been reassigned to duty with the British Expeditionary Forces.

Dr. Alice Hamilton of Chicago, a graduate of the University of Michigan and for several years engaged in the investigation of industrial diseases for the U. S. Department of Labor, has been appointed assistant professor of industrial medicine at Harvard.

Chicago women physicians and dentists gave a dinner, March 25, in honor of Dr. Barbara Hunt of Bangor, Me., who recently returned from France where she was director of one of the six hospitals controlled by the American Women's Hospital Association.

Gustavus M. Blech, Major, M. C., U. S. Army, who went overseas as assistant division surgeon of the 33d Division, has been promoted to lieutenant-colonel, M. C., U. S. Army, and is in command of U. S. Army Base Hospital No. 208, which is located near Bordeaux.

Harry D. Orr, Lieutenant-Colonel, M. C., U. S. Army, formerly commanding officer of the 108th Sanitary Train, 133d Division, has been appointed division surgeon of the Thirty-Third Division, which is located in the Duchy of Luxembourg near Treves, Germany, in reserve for the Third American Army.

Dr. Charles H. Franz, Aurora, after thirty years of practice in Illinois, during which time he was at one time assistant superintendent of the Elgin State Hospital and president of the Fox River Medical Society, has moved to San Francisco, where he is assistant surgeon in the United States Public Health Service.

Leon C. Garcia, Lieutenant-Colonel, U. S. Army; Herbert Walker, Major; Eugene Cary, Captain; Irvin S. Koll, Captain; Ralph H. Kuhns, Captain, and Lloyd H. Simmons, Lieutenant, M. C., U. S. Army, who have been on duty with the American Expeditionary Forces in France, have been released from military duty.

News Notes

Dr. A. Parker Hitchens, one of the foremost bacteriologists in the United States, has accepted an appointment as associate director of the biological division of the Lilly laboratories.

Dr. Hitchens has been secretary of the Society of American Bacteriologists for a number of years and is editor of the organization's publication, "Abstract of Bacteriology."

Marriages

MARK JAMPOLIS to Miss Janet Hill McKenna, both of Chicago, March 1.

FRANK NATHANIEL EVANS, Lieutenant, M. C., U. S. Army, Springfield, Ill., to Miss Gertrude Maw of Essex, England, March 12.

BENNETT ROLAND PARKER, Lieutenant, M. C., U. S. Army, Chicago, on duty at Nantes, France, to Miss Edith Helene Matthies, at Nantes, January 27.

MAURICE CHARLES PINCOFFS, JR., Lieutenant, M. C., U. S. Army, Chicago, to Miss Katherine

Brune Randall of Baltimore, at Catonsville, Md. March 1.

ANDREW MORTON CARR, JR., Lieutenant, M. C., U. S. Army, Chicago, on duty with the Presbyterian Hospital Unit, A. E. F., at Limoges, France, to Miss Ruth Carolyn Bennett of Springfield, Ill., at Limoges, recently.

Deaths

HENRY S. HASKINS, Highland Park, Ill.; University of Michigan, Ann Arbor, 1872; aged 69; a Fellow A. M. A.; died suddenly at his home, February 16.

GEORGE JACOB STUBENRAUCH, Chicago; University of Illinois, Chicago, 1910; aged 46; at one time a member of the Illinois State Medical Society; died at his home, February 23, from angina pectoris.

ABRAHAM H. LIFCHUTZ, Chicago; Barnes Medical College, St. Louis, 1899; aged 49; at one time a member of the Illinois State Medical Society; died at his home, February 28, from mediastinal tumor.

CHARLES OLAF H. NORDWALL, Rockford, Ill.; John A. Creighton Medical College, Omaha, 1906; aged 47; a Fellow A. M. A.; died in the Michael Reese Hospital, Chicago, March 7, from chronic interstitial nephritis.

JAMES M. G. CARTER, Los Angeles, Cal.; Chicago Medical College, 1880; aged 76; Fellow A. M. A.; member of Chicago Medical, Illinois State and Los Angeles Medical Societies; died at his home, March 1, 1919, from nephritis.

JOHN PALMER MATTHEWS, Carlinville, Ill.; Marion-Sims College of Medicine, St. Louis, 1892; aged 51; a Fellow A. M. A.; local surgeon of the Q., C. and St. L. Railroad; died at his home, January 23, from septicemia due to an infected tooth.

ALBERT N. RICHARDSON, Chicago; Rush Medical College, Chicago, 1872; aged 76; a quarantine officer of the Chicago Department of Health since 1901; died suddenly, March 24, while walking at 65th street and Lome avenue, from organic disease of the heart.

JOHN BISHOP HAZEL, Hoopeston, Ill.; Hospital College of Medicine, Louisville, Ky., 1883; aged 69; a member of the Illinois State Medical Society and a specialist in diseases of the eye, ear, nose and throat; died at his home, January 20, from heart disease following influenza.

LEO CASSIUS MILLER, Lieut., M. C., U. S. Army, Champaign, Ill.; University of Illinois, Chicago, 1906; aged 36; a Fellow A. M. A.; who served at Camp Greenleaf, Fort Oglethorpe, Ga., and was then ordered to the Embarkation Hospital, Camp Stewart, Va., in November, 1918; died at Champaign, December 14, from pneumonia following influenza.

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THE CORPUS LUTEUM IN ITS RELATION TO AMENORRHEA, STERILITY, ABORTION, AND PSEUDO EX- TRA-UTERINE PREGNANCY.*

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In recent years some very interesting facts have been observed by veterinarians on the influence of the corpus luteum on sterility and abortion in the cow and it has occurred to me that this data might be of great value in solving some of the similar problems in the human female.

It has been observed, for instance, that if a false corpus luteum remains unabsorbed in either ovary of a cow she does not come in heat, a condition which corresponds to amenorrhea in woman, and so long as the cow does not come in heat she, of course, remains sterile. On the other hand, as soon as this false corpus luteum is absorbed normally or expressed manually by the operating hand of the veterinarian, the phenomenon known as heat develops within twenty-four hours. This observation has been made so many times by a sufficient number of highly trained, experienced veterinarians that in the minds of the veterinary fraternity it no longer is a debatable question. I have had a number of patients with premature menopause, who gave the history of having suddenly stopped menstruating because of a severe chilling during a menstrual period and who have never menstruated since, and another considerable number of patients who, following a severe chilling or illness during a menstrual period, menstruated only at intervals varying from several months to several years who have had the distressing

symptoms of artificial menopause, whom today I would laparotomize, carefully examine the ovaries and if an unabsorbed corpus luteum were found, excise the same with the hope of relieving their symptoms, reestablishing menstruation and curing their sterility.

Veterinary surgeons have also made another very important discovery. Sometimes in expressing what they consider a false corpus luteum they have actually expressed or ruptured a true corpus luteum, in which instance one of two things has invariably happened, either the cow has bled to death in a very short time or she has aborted within from twenty-four to thirty-six hours. This observation on the cow throws very interesting light on two somewhat obscure problems in gynecological surgery, namely, the problem of abortion and the frequent finding of blood in the peritoneal cavity, which so frequently has been ascribed to ruptured extra-uterine pregnancy, but in which on careful examination, no placental tissue has been found microscopically. The experience of veterinary surgeons, as well as my own experience in operating on pregnant women, leads me to believe that abortions following abdominal traumas are caused by injuries to the true corpus luteum and not to traumatism of the uterus itself and that in operating upon pregnant woman the important precaution is to avoid traumatism of the ovary containing the true corpus luteum if one wishes to avoid interruption of pregnancy. I have operated on a goodly number of pregnant women in almost every stage of pregnancy for a variety of abdominal conditions, such as intestinal obstructions, hernia, appendicitis, gall-stones and even fibroids of the uterus without ever having caused an abortion and I believe this has been possible because I have always been very gentle with the ovaries at the time of such operation, not because I have known the fact that injury of the true corpus luteum would produce abortion, but because I have made

*Read before the Chicago Surgical Society on April 4, 1919.

it an invariable rule to treat all intra-abdominal organs with the greatest care and consideration.

The tolerance of the pregnant uterus to traumatism was indelibly impressed upon me some years ago. A woman three months pregnant with multiple uterine fibroids, one on the posterior surface of the uterus at the junction of the body and neck, insisted upon having an operation. She had lost two former pregnancies, one at the fourth month from abortion and the other at the time of birth from craniotomy, because the largest fibroid on the posterior surface of the uterus had made normal delivery impossible. She was very anxious to be the mother of a living child and argued that having failed twice she was willing to take almost any risk to save this pregnancy. The small fibroids on the fundus of the uterus were easily removed but the one on the posterior surface offered great technical difficulty and necessitated considerable traumatism. The patient, however, made an uneventful recovery never having any labor pains nor any uterine bleeding, went on to full term and gave birth to a living child. I firmly believe now that if I had injured the true corpus luteum this fortunate outcome would not have occurred and the resultant abortion would probably have been ascribed to excessive traumatism of the uterus.

In recent years a considerable number of articles have been written emphasizing the fact that in so many cases of supposed extra-uterine pregnancies, neither the fetus nor placental tissue can be found on the most careful search. My own experience has been along the lines of these articles. In quite a large per cent. of cases of supposed ruptured extra-uterine pregnancies neither the fetus nor placental cells could be found on the most careful search.

The observation of the veterinarians may explain why in such a large per cent. of supposed extra-uterine pregnancies no placental tissue can be found microscopically, in that, instead of these abdominal hemorrhages being caused by ruptured extra-uterine pregnancies they are really the result of a rupture of either the true or the false corpus luteum. If true corpus luteum, with resultant abortion and the finding of placental tissues in the scrapings of the uterus, if false corpus luteum, premature menstrual flow without placental tissue.

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A BRIEF STUDY OF GOITER*.

BASED ON ONE THOUSAND CASES OPERATED UPON.

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The greatest difficulty in the scientific study of goiter in its various phases and relations is the absence of standard nomenclature. Even a definition that really defines goiter has not been proposed. The old-time definition "An enlargement of the neck," even though modified by the phrase "Due to enlargement of the thyroid," is incorrect and unsatisfactory. Over fifty per cent. of the patients that we have seen with real exophthalmic goiter have had no enlargement of the neck. The most satisfactory definition that I can suggest is "A goiter is the diseased portion of a thyroid gland."

There is no classification for goiter that is standard. It seems that every goiter investigator adds to the already uselessly large number of divisions and classifications. This is perhaps due to the fact that the pathological classification bears so little relation to the clinical picture. The size of the goiter has small relation to its pathological classification or to its clinical picture. The exophthalmus may be the remaining symptom of an old hyperthyroidism that has long since changed into a hypothyroidism with destructive degeneration of the gland.

The symptoms of a case vary. At the first they may be due to acute hyperthyroidism, later to hypothyroidism and at last to thyrotoxis and pressure symptoms. A patient may have had almost every known symptom and conformed to almost every known classification.

We have used the following classification:

Simple goiter or an enlargement of the gland with no active systemic symptoms.

Hyperthyroidism.

Hypothyroidism and Mixed.

In our one thousand cases we had four hundred and ninety-three simple goiters; 219 of which had some pressure symptoms. We had 227 typical exophthalmic cases; 132 of the 227 had no palpable or visible enlargement of the glands; 95 had definite enlargement or tumor formation of some part of the gland; 39 of the 227 had pressure symptoms.

*Read before the Tri-State District Medical Society, in Madison, Wis.

There were 280 cases of hypothyroidism, thyrotoxic and mixed. The mixed were toxic and hypothyroidism or toxic and hyperthyroidism. Of these 280 cases 184 had tumors of the gland. In 96 no tumor or enlargement was visible or palpable upon examination but in every case tumor growth was found to be present at the operation. One hundred and ninety-seven of the 280 had some pressure symptoms. So 445 of the 1,000 had pressure symptoms.

The youngest was seven years of age, the oldest 69. Three hundred and twenty-seven were unilateral, 673 bilateral, 748 had hereditary history, 77 intrathoracic projections, 141 substernal or subclavicular projections, 119 had previously received serum treatment, 3 were malignant, 326 had exophthalmus. Seventy-nine were known to be tubercular before operation; 46 were suspected of being tubercular. A diagnosis of endocarditis was made in 530, auricular flutter in 37, auricular fibrillation in 182, organic lesions of the heart, 166; 134 had a history of rheumatism followed by heart trouble.

Almost every case with organic lesion of the heart gave a history of rheumatism with heart involvement years before the appearance of symptoms of hyperthyroidism. I do not remember of having seen a heart affected by rheumatism after a goiter was present.

In 1915 I reported blood pressure observations on thirty-five cases of goiter before and after operation. After doing considerable work on blood pressure we abandoned the investigation.

One-half of our patients have had endocarditis, not complicated by any other heart disturbance. The after result has compared almost uniformly with the condition of the heart at the time of operation.

Two patients were operated upon at the beginning of the third month of pregnancy, one at the beginning of the fourth month.

Several years ago we noticed that the removal of tonsils affected hyperthyroidism cases very favorably and for several years it has been our routine procedure to have the tonsils removed sixteen to twenty-one days before operating upon all cases in which serious heart symptoms are present. In preparation of the serious cases for operation 177 received hot water injections, 32 received quinine and urea hydrochloride injections; 409 received salvarsan. Twenty-seven

ligations of the superior thyroid artery and 32 ligations of the inferior thyroid artery were done.

Complications due to the operation:

One patient has a bad scar.

No injury has occurred to the recurrent laryngeal nerve.

Three parathyroids were removed inadvertently, seven deliberately. No cases developed tetany. No effect due to their removal was discovered.

After results:

Deaths, four.

Not improved or made worse by operation, none.

Those who are still invalids but definitely better than before operation, thirty-two.

Satisfactorily improved, four hundred and thirty-one.

Complete recovery, five hundred and thirty-three.

DISCUSSION

Dr. Baird of Galesburg, Illinois: Your paper was very interesting to me and I wondered how you act in cases of primary syphilis of the thyroid,—I believe you mentioned primary syphilis of the thyroid,—and I am wondering, it is not quite clear to me, how it would be possible to have a primary lesion—primary syphilis of the thyroid.

Dr. Sloan: I did not refer to the primary lesion. By primary syphilis of the thyroid we mean those cases that have no other known manifestation of syphilis.

Dr. Baird: Primary syphilis is always secondary then?

Dr. Sloan: Yes, those are the first syphilitic manifestations known to the patient. But in just what stage of syphilis the thyroid becomes involved I do not know.

Dr. Baird: What dosage of salvarsan do you use?

Dr. Sloan: Lately, I have been starting the treatment with small doses for very bad heart cases. It is wonderful what you can do with these heart cases by giving salvarsan.

RETROPHARYNGEAL ABSCESS IN CHILDREN: DIAGNOSIS AND CASE REPORTS.

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The frequency with which this condition contributes to the column of "missed diagnoses" has

actuated me to present this study of the condition from the standpoint of diagnosis. Unlike many other conditions whose diagnosis is of academic interest alone, inasmuch as their detection either offers no hint to therapy or their non-detection, little serious import to a self-curing condition, the diagnosis of this condition indicates at once therapy that relieves most acute agony and in instances saves life.

Perhaps its relative infrequency is the most important factor in its non-recognition. An investigation of the available statistics discloses a frequency in those places where one expects accurate diagnosis that gives rise to the suspicion of many non-recognized cases. Some of these possibly rupture spontaneously and others make their "exitus" under other guises.

The reports of the superintendent of the Johns Hopkins Hospital¹ for the years 1913-16, the previous years not being itemized, show that in the pediatric house patients numbering 2,595, there were 71 cases or 1 in every 370 cases. The annual reports of the trustees of the Massachusetts General Hospital,² 1906-14, show in the out-patients 56 cases, the age of patient and variety of abscess not being specified. The total number of new patients was 178,132, showing an incidence ratio of 1 to 3,181. The house patients for the same period show 11 cases in 53,599 on the medical and surgical services, a ratio of 1 to 4,872. The following table shows the number of cases occurring each year and includes all cases of pharyngeal abscess, the variety and age not being specified.

	Out Patients (New Cases)	House Patients (Medical & Surgical)
1907	11 in 20,359	2 in 5,376
1908	5 " 20,729	1 " 5,854
1909	5 " 21,518	4 " 6,465
1910	7 " 22,032	0 " 6,616
1911	3 " 22,232	3 " 6,581
1912	9 " 22,647	0 " 7,203
1913	10 " 24,887	0 " 6,841
1914	6 " 23,728	1 " 9,063
Total	56 in 178,132	11 in 53,599

Another factor is the difficulty of making a satisfactory inspection of the inflamed throat of an infant or young child, because of its small size, the fear and constant movements of the child which make it almost impossible to adequately illuminate the areas posterior to the tonsils. In homes, apprehensive attendants holding the patient and their unwillingness to add to its suf-

fering tend to cause a sympathetic physician to relinquish his exploration before he has completed his inspection. Palpation likewise fails to give conclusive evidence to the unpracticed finger, for here again the squirming and gagging of the child throws the anatomic relationship of the tissues into chaos and again the examiner desists rather than brave the advancing indignation of the adult relatives. In order to secure results, with minimum distress to the patient and family, the examiner should possess a clear conception of what he seeks and an effective manner of finding it.

Pharyngeal abscesses divide themselves into three classes from an etiologic standpoint, tubercular cervical caries, the lodgment of foreign bodies in the pharyngeal mucosa, and catarrhal rhinitis or pharyngitis of grippe, influenza, scarlatina, diphtheria and measles. While regarded formerly as a cellulitis, "an accumulation of pus in the cellular tissue between the pharynx and the vertebral column," they have come to be considered in nearly every case, an adeno-phlegmon.

The anatomy of the retropharyngeal lymph glands is of importance in understanding the location of the abscesses. Delamere, Porier, Cunco and Leaf³ in their work on the lymphatics give the following description of these lymph glands:

"The retropharyngeal glands are placed behind the pharynx at the junction of its posterior and lateral surfaces and at the apex of the lateral masses of the atlas. These glands are usually two in number. According to Most, however, it is the rule for one gland only to be present. When these glands are two in number they lie over one another in the vertical plane. These glands are in relation in front with the posterior wall of the pharynx; behind, with the rectus capitis anticus major, which separates them from the lateral masses of the atlas; externally, with the constrictors of the pharynx, and through the latter with the internal carotid artery; internally, they are nearly two centimeters distant from the middle line.

The retropharyngeal glands receive as afferents almost all the collectors coming from the mucous membrane of the nasal fossæ and the cavities in connection with it, the lymphatics of the nasal pharynx, those of the Eustachian tube, and perhaps some of the lymphatics from the cavity of the tympanum. As has been seen, their lym-

phatic area is very extensive and the frequent infection of these glands is easily explained.

The efferent vessels of the retropharyngeal glands empty themselves into the superior glands of the internal jugular chain. To reach these they pass, for the greater part, behind the vessels and nerves, and more particularly the superior cervical gland, the posterior surface of which they cross."

To the abscesses originating in the retropharyngeal glands the term "retropharyngeal abscess" is applied, and to those originating in the superior glands of the internal jugular chain the term "peripharyngeal" has been applied by Broca and later modified to "parapharyngeal" by Heiman.

The symptoms and signs by which the acute variety of retropharyngeal abscesses are recognized are illustrated by the following cases:

Case 1. C. G., aged 6 months, Russian Jew. First child, with negative natal, family and previous histories. Breast fed. Three weeks previous the patient had become feverish and the attending physician had diagnosed grippe. For a few days there was improvement, then the patient became worse, with fever, disinclination to nurse, slept poorly at night and preferred to be held. A swelling appeared under the right ear a week before presentation.

Examination disclosed a pallid, fairly well nourished infant, whose body revealed nothing of interest aside from the throat and neck findings. Externally, there was a large lymph gland, tender without superficial redness. Inspection of the pharynx revealed a tumor situated in the right lateral wall just behind the tonsil, but clearly separated from it. There was fluctuation. Incision released a large amount of greenish pus. The inflamed external lymph gland absorbed under hot boric fomentations. Recovery rapidly ensued.

Case 2. C. M., aged 11 months. First child, natural birth after normal pregnancy. He was breast fed for three weeks, when because of sore nipples and breasts bottle feeding was instituted. A variety of foods was used, with the result that at eleven months he was pale and underweight (13 pounds and 6 ounces), and the skin was somewhat atrophic and clammy. The present attack was ushered in by symptoms of influenza, which had been present for six days when I saw the patient. The temperature was 103 degrees, respirations rapid and noisy, the dyspnea and discomfort apparently acutely increased when the head was lowered, so that some one had been obliged to sit up and hold the child continuously for the preceding forty-eight hours.

Inspection showed the entire pharynx much swollen, the tonsils less so. Directly behind the left tonsil appeared a mass projecting more toward the median line than the tonsil. Incision with a guarded bistoury was followed by a scanty flow of pus, perhaps a dram. The

patient's dyspnea and pain were much relieved and he had a fair night's sleep in the recumbent position. A few days later it was necessary to incise the other side with similar results. The patient subsequently developed pus inflammations of five of the cervical lymphatics, anterior superficial groups, which finally cleared up under drainage, dietetic measures, and cod liver oil.

Case 3. E. K., aged 1 year. This was an adopted child and nothing was known of its history up to the time of its adoption. It was bottle fed and had done badly, as its extreme pallor and under weight showed. A week previous it was noticed that the child was feverish, and the physician who was called diagnosed grippe. The child failed to improve and the throat became more swollen daily. Several smears were cultured for diphtheria bacilli without success. The striking symptoms were the inability to swallow and the orthopnea. So extreme was this that complete apnea instantly occurred on laying the child down. Breathing began when the upright position was assumed.

Examination revealed a mass in the left post-tonsillar portion of the pharynx. It was fluctuant. The other pharyngeal structures were hyperemic and hyperplastic to a considerable degree. The infant was in an advanced stage of exhaustion, the respiration and pulse being both rapid and irregular.

An incision was followed by a very profuse flow of yellow pus. The breathing was immediately relieved and the child sank into a restful sleep lasting perhaps an hour. Awakening coughing, it developed an acute respiratory distress and expired in about eight hours with the signs of an acute pulmonary edema or an acute pneumonia. There was no postmortem.

Case 4. H. W., aged 12 months. American born of Russian Jewish parents. First and only child of healthy parents whose family history was negative for lues and tuberculosis. Prenatal, natal and postnatal histories were negative. He had suffered from several attacks of bronchitis, so-called. For two weeks previous the patient had given the usual signs of fever and had coughed. The cough had gradually increased in severity and frequency. There was no history of a distinct paroxysm.

Examination showed a robust child, adipose in type, with nothing of positive interest except in the throat. The pharynx was nearly occluded, the right wall being slightly less tumescent than the left. The uvula was enlarged and pendulous. Both tonsils showed marked hyperplasia. The symptoms were quite interesting in that the infant seemed fairly comfortable when awake and sitting up, but immediately upon laying him down or upon his falling asleep, he was disturbed by an inability to breathe. He endeavored to relieve himself by awakening partly, turning over in bed and coughing. The cough was a short, sharp, unproductive hack, almost constant when he was lying or attempting to sleep. There was no distinct fluctuation present.

Without a clear indication, therefore, a puncture was made on the most protuberant point of the left-sided mass which emitted a small amount of pus visible on the scalpel and in thin streaks in the bloody

expectoration. The uvula was removed at the same time.

The immediate effects while not striking, were encouraging. It was necessary to open the incision in the pharyngeal mass at four different times with a spreading forceps before the relief was marked. The swelling of the pharynx abated slowly and it was some three weeks before the cough stopped. The breathing continued noisy due to the presence of adenoids.

Alexander⁴ in reporting 22 cases of retropharyngeal abscess says, "The symptoms are those of a cold for a few days, irritable and has difficulty in swallowing, a peculiar croupy cough with each inspiration which seems to be painful. It prefers to be carried, the head in an upright position with chin forward. There is pain on movement of the head. When the abscess becomes large enough to press upon the larynx, severe dyspnea ensues."

Koplik⁵ in his report of 77 cases says: "The symptoms are not at first distinctive. The development is insidious. At the outset there are the symptoms of ordinary tonsillitis or pharyngitis. The fever is high at the beginning. After the acute symptoms subside it is noticed that the lymph nodes at the angle of the jaw continue to be enlarged, and that the fever continues to show a remittent type. There is some prostration, the infant does not nurse properly, cries, and is frequently restless. Inspection of the throat on the fourth or fifth day of a tonsillitis may reveal nothing except some swelling or edema of the posterior wall or of the pillars of the fauces, no tumor being visible. After an interval of a few days, generally on the seventh or eighth after the initial symptoms, it is noticed that the voice of the infant has a nasal quality, that the head is thrown back, and that the breathing is noisy and nasal. If the tumor is allowed to increase in size, there is pronounced interference with the breathing."

Kyle⁶ writes: "There is stridulous respiration, both inspiratory and expiratory, and the voice is altered. The expectoration is slight and not membranous, but the cough is of a hacking quality. There is marked difficulty in swallowing, with external pressure tenderness. The dyspnea is marked, and may even be paroxysmal; it is aggravated by swallowing, which is not the case in croup. The dyspnea is increased by pressure on the larynx, and is aggravated when assuming the horizontal position. This is not true in croup, although in membranous inflammation change of position will bring about paroxysms of dyspnea, on account of the shifting of the membrane."

Fedde⁷ mentions as the principal symptoms, "fever, prostration, changed cry resembling a duck quack, dysphagia, obstructed breathing, noisy mouth breathing, a fixed position of the head backward and toward the affected side, swollen glands at the angle of the jaw and visible pharyngeal bulging."

Summarizing the salients by which we may

arrive at a diagnosis, there is first an antecedent history of an inflammation in a tissue tributary to these glands. It may be in the form of an otitis, posterior rhinitis, tonsillitis, pharyngitis, or the insult of a foreign body. It may be influenza, measles, scarlatina, or diphtheria. The age of the patient is under three, as these glands usually atrophy at that age. There may be an interval of apparent improvement after which the patient becomes progressively worse. There is fever and leucocytosis. The cry suggests the cry of a duck. The symptoms referable to the phlegmon are aversion to swallowing food or drink because of the dysphagia. There is noisy mouth breathing and dyspnea, which is increased in sleep and on lying down to orthopnea and apnea. There is a hacking dry cough, also increased in sleep and on lying down. The head is held backward and erect.

Very interesting and striking is the marked interference in breathing caused by laying the child down. It was present in three of my four cited cases and is mentioned by Kyle. It may possibly be due to the flexion of the head on the chest with its consequent encroachment of the phlegmon on the epiglottis. The added coughing discomfort during sleep is due possibly to the relaxation of the muscles or the dulling of the deglutition reflex incident to sleep. One notes, in observing these cases in sleep, that they sink into a sleep very quickly, due to their exhausted state and sleep but a few moments when they seem distressed in breathing and partially awaken to cough or swallow, then sinking again into sleep only to repeat the process until they are relieved by rupture or incision of the abscess.

In a differential diagnosis there is first to be considered that variety of retropharyngeal abscess secondary to tuberculosis of the cervical vertebra. This is slower in onset, is usually without acute leucocytosis, and fever. M. Howard Fussell⁸ in his article on this subject says, "In caries there is tenderness and fixation and extreme pain on moving the neck. This is entirely absent from abscesses due to local infection. An x-ray will demonstrate caries of the spine." The swelling of acute phlegmonous pharyngitis is distinguished by the uniform contour of its swelling and the abscess of fluctuation.

The dyspnea may suggest laryngeal diphtheria, which evinces a croupy cough, suppressed voice, possibly a symmetrical swelling of the larynx, pos-

sibly visible membranes associated and positive cultures, as opposed to hacking cough, duck quack voice, a symmetrical swelling and negative Klebs-Loeffler cultures. The dyspnea of diphtheria is not increased by postural changes.

The increased cough in sleep is common to intumescent enlarged tonsils and elongated uvula, which can be eliminated from consideration by a careful inspection.

Foreign body stenosis of the larynx may simulate in the dyspnea and cough, but can be distinguished by the history, a skiagram, postural changes, etc.

Peritonsillar abscess or "quinsy" is never found in small children under the age of three and acute retropharyngeal abscess never after the age of three.

From parapharyngeal abscess a diagnosis is made by Heiman⁹ as follows:

In our opinion, there is little doubt that the variety of abscesses we have styled parapharyngeal, because their site is by the side of, or lateral to the pharynx, exists as a separate entity and may be distinguished from the retropharyngeal type. The retropharyngeal abscess may produce a central bulging, though usually somewhat lateral to the midline; it does not displace the tonsil; it is, as a rule, accompanied by edema of the pharynx and uvula, by a brassy voice, with the symptoms of more or less pharyngeal stenosis, and at times by a retraction of the head. On palpation a distinct cushionlike feeling or fluctuation may be obtained. The parapharyngeal abscess produced bulging nearer the lateral pharyngeal wall, if at all internally, but rarely in the midline; it nearly always displaces the tonsil—and this is a very important point in diagnosis—*toward* the median line, and is rarely accompanied by any marked local change in the appearance of the pharynx, or by any symptoms of pressure on the larynx. In the case of retropharyngeal abscess, internal incision usually cures, unless the suppuration extends to the lateral columns of the pharynx, at which stage the retropharyngeal becomes a parapharyngeal abscess and then requires an external incision, or burrows its way into the mediastinum. The retropharyngeal abscess is usually diagnosed early, while the parapharyngeal abscess may progress for one or two weeks before a diagnosis is made, or before the external swelling becomes sufficiently prominent to justify an external incision. Of importance also in the differential diagnosis is the age of the patient. As the retropharyngeal glands atrophy before the child is 3 years of age, an abscess in this region in a child over this age is more likely to be of the parapharyngeal form.

Method of examination. As these patients are distinctly more uncomfortable when laid down, it is better to have them seated on the nurse's knee with the arm nearest the nurse passed to her back.

The nurse holds the child closely to her with one arm and with the other holds the free hand of the child, who faces the best light available. The physician stands directly behind the child and grasps its occiput firmly in one hand to rotate or extend the head so as to bring it into the best line of vision or light. The other hand then inserts the tongue depressor to the base of the tongue and makes a slight forward traction. The physician's gaze is directed from above and just under the upper incisor teeth to the pharynx. This angle of vision requires a minimum of tongue depression and has the added advantage of keeping the examiner out of his own light and removes him from the possibility of being showered with bacteria when the child coughs. A firmly held child gives less trouble, as he soon realizes the futility of further struggle and signifies his submission by opening his throat to cry, at which time the view is unobstructed by tongue, uvula or tonsils. One clear glance should suffice. Palpation is more difficult. With the principals in the same position, the finger is inserted between the teeth and the cheek past the tonsil to the mass, a quick firm pressure made and the finger quickly extracted, as the child will gag and vomit if the palpation is prolonged.

In conclusion let me say that missed diagnoses of acute retropharyngeal abscesses will be fewer if physicians will keep in mind their comparative frequency in children under three, and if they will make throat examinations with an efficient technique, at the same time keeping in mind the salient points in the diagnosis of this condition.

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FINAL REPORT OF THE QUACKERY COMMITTEE APPOINTED BY THE DOUGLAS PARK BRANCH OF THE CHICAGO MEDICAL SOCIETY.*

HENRY R. KRASNOW, M. D.

CHICAGO.

This subject has been presented to you before on two occasions, and I do not wish to repeat

*Read before the Douglas Park Branch of the Chicago Medical Society, March 18, 1919.

myself this time. I shall, therefore, briefly try to sum up in conclusion the suggestions heretofore stated.

The papers read before this society on this subject concerned chiefly the foreign populations of this country. Reasons were given to prove that, as far as the English-speaking people are concerned, a great deal has been done and is still being done to stamp out the evil, although there still exists an enormous amount of this menace among the natives of this country.

That quackery flourishes most among the foreigners of this country can at this time hardly be denied, because it was confirmed by the discussions following the reading of the previous papers as well as by expressions of comment from members of the medical profession of various parts of the country after they had acquainted themselves with the subject. And, as this is the final presentation of the subject for discussion on my part, I must confess, I feel that the solution of a problem has been undertaken equal to almost an impossible task; to quote Dr. W. J. Denno of New York: "The eradication of medical quackery is a matter not of years, but of generations."

If experience is our teacher, we may learn that as we live and strive, we succeed and progress. Who will deny that even in the last four or five years we have witnessed the decline, to a considerable extent, of medical quackery. As far as my personal experience goes, I can, with equal assurance, confirm the belief that persistent efforts will undoubtedly bring results. For a number of years I have been and am now lecturing before Russians in Chicago and other American cities on subjects of hygiene and physiology; and these people appreciate the subjects very much. I have initiated in the Russian press of this country the Department of Popular Health, and similar departments are now found in almost every other newspaper, because the readers enjoy the subject. I have published a monthly magazine, dealing with subjects pertaining to popular health and evil-doings of medical quackery, and the publication has met with universal approval.

As may be noticed, the various "doctors" of the various "cults," such as osteopaths, chiropractors, etc., were not mentioned by me in the previous papers. To be more comprehensive, we shall, therefore, consider them briefly, too. In doing this, in due consideration to Dr. William

J. Robinson of New York, we shall mention them in the following classification: Christian Scientists; Mental Healers; Osteopaths; Chiropractors; Dietary Quacks; Medical Institutes, and Quacks in General.

Summing up his brilliant treatise on the subject, entitled, "Scientific Medicine vs. Quackery," Dr. Robinson comes to the following conclusions:

1. The human body is a very complex and very delicate organism. To understand its normal mechanism (its physiology), and its abnormal derangements (its pathology or disease), requires years of theoretical study and practical experience.

2. The public is not capable of judging as to who is and who is not a competent physician, any more than it is capable of judging as to who is and who is not a good steamship captain, a good electrician, a good chemist, a good engineer, a good astronomer, a good mathematician. Only competent boards from respective professions or trades can decide that, more or less satisfactorily.

3. Without laws and regulations for the practice of medicine, the country would be overrun by ignorant, conscienceless quacks, deceiving, cheating and preying upon the public; and the damage to the people's health and increased mortality would be something fearful.

4. To talk of free competition in the practice of medicine shows defective mentality. Medicine is not a trade like selling shoes or clothes. When a person has had his health ruined, or has been driven to an untimely grave, then it is no consolation to him or to his relatives to know that the doctor who treated him was an ignorant, unlicensed quack. It is too late then. The quack should not be given the opportunity to succumb, in the survival-of-the-fittest struggle, *after* he has done incalculable damage; he should be prohibited from entering into the struggle; he should not be punished after his misdeeds, he should be prevented from committing them.

5. The laws which we demand for the regulation of medicine are most emphatically not for the protection of the medical profession, but for the protection of the people. We are willing to admit anybody to the practice of medicine who can give proof that he is, more or less, competent to perform the delicate duties of a physician.

6. That there is incompetence and ignorance in the medical profession is admitted, but the remedy for it is not letting down the bars for all comers to enter, but raising them still higher; so that eventually only really competent and intelligent men and women may be entrusted with the heavy responsibilities of healing the sick.

7. The regular medical profession is aware of its shortcomings, but it is honestly trying to eliminate them by raising the standards of preliminary education, by enlarging the curriculum, by increasing the number of years required for completing the medical course, by extending the laboratory facilities, by recommending hospital experience as an obligatory part

of medical study; in short, it is doing everything in its power to raise the standard of the physician of the future. While as to the quack, all HE demands is the abolition of all criteria, of all standards, of all educational requirements.

8. The statement that drugs are absolutely useless, and never are of any benefit in the treatment of diseases, proceeds from the ignoramuses who have not used, and are not familiar with the action of drugs. I make the positive statement that there is not at the present time a *single physician of any eminence* who denies the value of drugs. He may object to the abuse of drugs and to too great a reliance on them, but not to their proper use. And there is not a single physician who does not use some drugs occasionally. And what is more, the fakirs who publicly decry the use of drugs as poisons, use some few drugs secretly in their practice. But, of course, the drugs they use are "all right," because they are "mild and harmless"—as they say.

9. The idea conveyed by quacks, physical culturists, naturopathic (so-called) doctors, osteopaths, and that ilk, that the scientific medical profession treats by the means of drugs only, is utterly false. There is not an agency in the world, material or immaterial, which the regular medical profession does not use in the treatment of diseases. As to diet, it is an important subject of study with us, and the real advances in the science of dietetics and the nutritional value of foods, are made by the medical profession, and the physiologists and chemists who work hand in hand with that profession.

10. No conciliatory attitude is to be adopted with the Christian Scientists, Mental Healers, Absent Treatment Quacks, Osteopaths, Chiropractors, etc. The greater part of their claims is impudent fraud, while the grain of truth in some of the cults is incorporated in the regular system of medicine.

11. As to various quack institutes, consumption and cancer specialists, lost-manhood professors, etc., etc., they should be treated as ordinary bunco-steerers, or as highway robbers are treated. They are worse than common thieves. They deserve no consideration, as they show none toward humanity. Unless they agree to give up their practice absolutely, they should be driven out of the country, or put behind prison bars.

We shall now direct our attention to a few characteristic examples found in a few cases of actual every-day incidents from the realm of sad results of medical quackery, to illustrate the consequences as far as the foreign masses are concerned.

Generally speaking, quackery is really such a many-angled, everlasting and illimitable subject, with so many ramifications, that, although dozens of volumes might be written upon it, and hundreds of examples of equal individual interest might be cited, we shall, for obvious reasons, confine ourselves to the discussion of only a very few

different instances, which will give a general idea of the various phases of the situation. With your kind permission I shall relate to you about two or three special cases of recent date:

Case A. Female patient; age 52 years. Complaints: Severe pain in the left orbital region. Insomnia. General weakness. Unable to attend to daily work as housewife. She was treated by her previous physician for everything imaginable. Upon examination: Both patellar reflexes were abolished. Argyll-Robertson pupil present. Chest: Heart exceedingly enlarged; while I could not be certain of aortic disturbance, yet was justified in suspecting it. All this, plus some adenopathy, especially in the pretracheal region, led me to suspect chronic lues, which had terminated in *tabes dorsalis*. Accordingly, a Wassermann was made, which gave one plus positive reaction. Not being satisfied with this alone, a spinal puncture was made which gave the following findings: Cell count, 30. All the globulin tests, including the Noguchi, Rose-Jones, as well as the Lange, were positive. The Wassermann gave a positive reaction.

Case B. Man; age 35 years. Laborer, Russian. Came to my office complaining of a "sore" in the left knee joint. There was tenderness. Swelling, which was at times less than usual. Asking him what treatment he had received, he gave the following history: He had been working as an unskilled laborer in the baggage department for a certain railroad company in the East, and through his occupation he had received a blow in the sacro-iliac region by a passing handcart; this had laid him up in bed for a week or two. He finally had recovered, but noticed that his left knee joint was somewhat painful, especially after a hard day's work. He went to his physician, who told him it was rheumatism, and advised that his teeth be x-rayed, and that those teeth which had pyorrheal pockets be removed. After having removed those infected teeth with no apparent results, the doctor advised that his tonsils also be removed; and that was done. As per his statement, "It took about five weeks for the wounds to heal up after the operation." Patient got worse, left the doctor and went to another physician who pronounced the case, tuberculosis of the knee joint, and ordered him to have the knee joint put in a cast; to this the patient refused to submit. At that time he happened to come across a quack's advertisement in a Polish newspaper, which promised a "cure within a week, or no pay"; but he charged him \$50.00 for the medicines. Lotions and ointments were applied for a period of a week, that produced such severe dermatitis that he became bed-ridden. I was called in to see him and my suspicion was that this might be a luetic affair. By obtaining his history, I found that he had a chancre about twelve years ago, and received the so-called mixed treatment per mouth for about three months. Wassermann was now made and gave 3 plus positive reaction. He got much better under antiluetic treatments, but left for the East; and I lost track of him.

Case C. Male patient, aged 30 years. Came to me

with severe frontal headaches; told me that his former physician (a quack by the way), after feeding him with all kinds of remedies, charging him heavily, with no success, decided that, if he would spend about \$45.00 for examination of the eyes and fitting glasses, it would stop the headaches. When the patient told him he could not pay at once such a sum of money, the doctor answered, "If you do not get glasses within one week, you will get blind." He became frightened, and sold much of his necessary belongings to get the wonderful pair of glasses. After having worn the glasses for about two weeks with no apparent change, he came to my office, asked if I would not send him to a good eye-man, an oculist, to fit a pair of glasses. He had been so thoroughly impressed with the statement that all his troubles were due to the eyes I had hard work to persuade him that, while there might be an element of truth in the statement, I could not recommend any treatment by an oculist unless I found that this was called for. I, therefore, examined him, and noted that he was somewhat anemic and jaundiced. His physical findings were as follows: the heart was somewhat enlarged, apex about one inch away from normal line. Blood pressure was low. Pulse, slow and thin. Somehow, he appeared to me to be as a case of malaria. And upon questioning him, I found that he had in his youth malaria. I suggested a blood count and Wassermann (in these cases a Wassermann is always advisable). I called the attention of Dr. Gruskin's Laboratory; asked them to look for the plasmodium, which was not found at the first examination. He came to me a week later, during the paroxysm of chills and fever. Another blood count was made; the plasmodium of the estivo-autumnal type was found present. Patient was put on an arsenic, iron and quinine, etc., treatment; and in about three months' time he was considerably improved.

I am certain that the average physician can, with assurance, give numerous examples of a similar kind. And these are instances, by the way, coming to us mostly from the so-called licensed quacks, concerning whom Dr. Robinson speaks in the above cited conclusions of his classification.

However, Dr. Robinson's paper was written a long time ago, and since that time, due to the propaganda of the various educational factors, the public knows better; and the quack is almost driven from the possibility of robbing, with equal success, the average American. And as was stated before, the quack, with greater audacity, began to prey upon the ignorance of the foreigners. Not only did the old-fashioned quack find a great field among the foreigners, but an entirely different, a new class, I should say, of medical quacks have established themselves among the foreign masses.

A brief classification of the different kinds of quacks, the unlicensed ones, may be given as follows: midwives, barbers, unlicensed druggists, mere fakirs, as self-styled "doctors" and "professors," clairvoyants and fortune-tellers, "healers," magicians, etc., etc. The various brands of patent medicines should also be taken into consideration. It will be safe to say that the last mentioned class of quackery is, in most cases, by far more dangerous than the so-called licensed quacks, because the results of the usually illiterate quack always bring grave consequences when a disease of complicated origin presents itself to him.

A few examples of how unlicensed ignoramus work will be further noted. They are doing their work by getting patients through publicity campaigns, by distributing pamphlets, cards, etc., and also by advertising in the newspapers. Here is a translated piece of literature (a small, pocket size card): "The world's greatest adviser. Gives the best advices in every affair; that means in business, work, love, family trouble, etc. This world's greatest mind-reader will also advise you in matters of family affairs, of illness, past and future, etc." * * * The latter is an example of a product of a foreign-speaking quack, of which class there is an enormous chain.

Here is another example of one who very widely advertises himself as "The only Russian-Polish Specialist on all the Patent Medicines—Dr. M. T-a." He hails from Montreal, Canada, but should you happen to be sick, it does not matter where you live, this "specialist" invites you "either come or write to me, and I will help you, because I am the only one, etc." A further translation of his widely distributed "literature" sent broadcast, states that:

Whether you suffer, and you have severe inflammation of the kidneys, sugar disease, kidney stones, complete obstruction of the urine, inflammation of the urinary bladder, male and female disease of the sexual organs, chancre, clapp, syphilis, bubo, bloody urine, gonorrhea, chordea, abscess, *sexual weakness pollution*. Special remedy for sterility, whether male or female. Do you suffer with stomach? Do you suffer from headache? Neuralgia? Do you cough? Do you suffer from asthma? Do you suffer from rheumatism? Acute or chronic? Do you suffer with nerves? Are you anemic? Does your hair fall out? Don't you wish to get fat? Don't you feel nauseated? Do you suffer from skin diseases, itching or eczema? Don't you suffer from lack of appetite? Do you have pimples or freckles? Do you have ingrown nails? Are not your

fingers crooked? Do you wish to dye your hair a different color? Do you have wounds? Don't you suffer from sleeplessness? Don't you suffer from heart disease? Don't you get fat or thin? Does not your back ache? Do your eyes smart or pain? Do you feel pain in your hands or feet? Do your kidneys bother you; your teeth? Do you suffer from pain in your throat? Don't you suffer from catarrh of your stomach? Are you troubled with constipation? Do you suffer from enlarged glands? Do you sweat at night? Do you suffer from chills in your hands and feet? Do you have severe heart palpitation? Don't you have bad dreams? Are you baldheaded? Would you wish to grow some more? Do you suffer from worms? Does it ring in your ears? Don't you suffer from nose or ear disease? Would you like to be handsome? Would you like to become strong again? Do you suffer from epilepsy? Do you suffer from anemia? Do you suffer from chicken-blindness? Would you like to have long and beautiful hair? Don't you suffer from pain under the chest? Don't you suffer from general weakness? Onanism, lifelessness? *Whoever suffers from all these diseases shall immediately apply to the only Russian-Polish specialist, etc."*

This "patent medicine specialist" is not a doctor at all.

A drug store in New Jersey advertises itself as The Saint Michael Pharmacy. With every advertisement there is an illustration of an old monk, dressed in a long robe, a belt with a large cross in his left hand; in his right hand he exhibits a bottle which is explained to be "St. Michael's Curable Balsam," which, by virtue of its sacredness, is supposed to heal every illness under the sun. If you happen to write for some help you are certain to receive a detailed biographical sketch:

The Saint Father Michael was a revolutionist of his times. He was sentenced for his ideas, to serve at a certain secluded wilderness in Siberia, Russia, for some kind of a crime against the government. He graduated from St. Petersburg Medical University, and lived as long as 108 years. In that secluded wilderness the Saint Father Michael occupied himself by collecting different kinds of herbs, seeds and other vegetables; from these he prepared various concoctions and infusions. Some of these he was cooking for a period as long as seven days; others he would leave to become cooked facing the sun for a duration of 40 days; afterward he would submit these preparations to experiments on himself, to see whether this or that medicine would act properly. Consequently he was in a position to find one definite remedy, which is capable of curing without exception, all existing diseases, such as clap, chancre, sexual weakness, syphilis, rheumatism, etc., etc. Saint Father Michael was never ill from any disease because he drank his balsam every day. Near his unassuming

and simple little dwelling there were always crowded thousands of people, mostly the blind, deaf and dumb, lame, crippled by rheumatism and tuberculosis, and others. All of these unfortunates would spend weeks and weeks waiting until they were fortunate in getting their next turn, in order to have the chance to face and consult the Saint Father Michael, from whom they expected to get relief. But as a reward, they left him, contented, happy and healthy. They would immediately feel that the Saint Spirit was hovering over their heads; and those whom it was necessary to bring on wagons, or by means of other vehicles, broken by paralysis, also otherwise dangerously sick and disabled, were now in condition, alone, without any help or assistance, to walk home. *The blind ones could see, the deaf could hear!* And all the other sick ones, who had suffered for many years, got well.

The secret of the Saint's prescription was disclosed as follows: "When Father Michael died nobody remained of his flesh and blood whom he could endow with that which had saved so many thousands of lives; and only the fact that Father Michael could not conscientiously lay quiet in his grave when he heard from the other world so many pleas and prayers for his help, made him, after twenty years spent in his grave, reappear as a casual traveler; and thereupon immediately appeared a marble wall upon which all of his prescriptions were inscribed." And the name of that prescription is "The Balsam of the Saint Father Michael," which can be procured at the Saint Michael Laboratory, Carlstadt, New Jersey.

Another similar so-called laboratory is situated right here within our midst, on Halsted near Eighteenth street. The owner of the place is not a chemist nor a druggist. He somehow happened to create a mixture of some kind of herbs. This mixture he advertises very extensively in a number of foreign language newspapers as a cure-all remedy, especially female troubles. The place of business, to the eye of the ignorant foreigner, looks very much like a drug store; and the people come to the place, the so-called drug store, not only for the purpose of procuring the wonderful remedy of the owner, but also to buy different chemicals and also to have prescriptions filled. This quack proprietor not only does that, but he treats people for all kinds of ailments. On one occasion he treated a case of diphtheria and the case somehow fell into the hands of a regular practitioner, who did not consider it important to report, feeling assured that the case was already reported by the previous physician. When

the patient died the entire affair was disclosed. The self-styled doctor-druggist could not even be prosecuted. According to the laws only a properly licensed physician could be punished for not reporting contagious diseases.

A number of people in my neighborhood told me of a barber around the corner who treated people for various maladies, mostly venereal. It is interesting to relate the experience of Mr. Z-ra, who is the investigator for the Illinois Board of Registration and Education. This investigator entered the barber shop, called aside the barber, and told him that he was sick with chronic gonorrheal urethritis and wanted to be examined. The barber invited the "patient" into the rear "examination room," which is a toilet. He confirmed the diagnosis, after which he promised to cure the investigator for ten dollars. The investigator paid one dollar as deposit and promised to come later for treatments. Instead, he came in the afternoon with a warrant to arrest the barber, but the latter refused to confess any knowledge of Mr. Z. or acquaintance with him. The case, nevertheless, came up in a few days, but the barber insisted that he never in his life had met the man who accused him. He was discharged by the court as a free man.

The same Mr. Z. told me of another similar case, where a written statement was obtained by the Board from a maltreated young Russian patient. It concerned a certain quack who posed as a professor of medicine, but who really was not even a doctor. For the last five or six years he moved from one place to another and could never be apprehended by the authorities, in spite of the fact that there were a number of indictments against him. In the case now discussed he treated this patient for chancre; but balanitis had developed and the patient went to a physician. When instructed to go to the quack and get his money (twenty dollars) back, the quack started a fight with the patient. The patient met Mr. Z., gave Mr. Z. a signed statement; and Mr. Z., the investigator, armed with a warrant, entered the quack's healing temple. The quack asked Mr. Z. to wait just one minute until he could get dressed. Meantime he entered another room and disappeared for good. About five or six months have elapsed since this occurred. The quack is still being searched for, but with no apparent results of finding him. However, I am sure that he is still successfully practicing at some secluded and conveniently situated location,

just as before, preying upon the ignorance of the unassuming foreigners.

There is a drug store on 14th street; and the daughter of the druggist is a midwife. Whenever a call comes in to the drug store for a doctor, and the patient happens to be a woman, the clerk sends this midwife to make the call. She calls on the patient, examines her, charges two dollars for the call, and promises that medicine will be delivered. She does not prescribe, for obvious reasons. For the same reasons the prescription does not bear any number; simply a label stating: "Cough Remedy," or "Stomach Remedy," as the case might be.

Necessary mention must be made of the great number of patent medicines advertised in the newspapers. I shall simply pass up such a cure-all remedy as Nuxated Iron, which, to the disgrace of many first-class English newspapers, finds space in their columns. A simple cathartic remedy is in most cases advertised to cure all kinds of blood diseases, headaches, stomach and intestinal disturbances, etc., etc., During the recent influenza epidemic, these same cathartics and laxatives were hailed as a successful treatment of the influenza. Other cure-alls are the different liniments that appear in the big advertisements, to relieve and to cure every disease on earth. Not long ago I was called in to see a patient with acute articular rheumatism. He was in bed for the two previous weeks, and during all this time he used up two bottles of Sloan's Liniment, and three bottles of Pain-Expeller, another widely advertised nostrum. He had quite a temperature, which was probably due also to the fact that he had been constipated for the past four days. So great was his confidence in these liniments that he could not see any sense in my orders for internal medications, for the natural purpose of bringing about general elimination.

I could cite many more similar cases, but I am afraid I have already burdened you. The fact cannot be denied that we are confronted with a great and important problem; and it is equally manifest that something must be done. Allow me to assure you that our efforts will never cease. As mentioned before, persistence will in the end bring the desired results.

Again let us see what really is the underlying cause of this quackery evil. In the opinion of Samuel Hopkins Adams, the author of "The Great American Fraud," a series of articles on quackery and nostrums: "All this advertising is

based on the well proven theory of the public's pitiable ignorance and gullibility in the vitally important matter of health."

There are, no doubt, many other reasons to account for the existing evil. Sufficient is to mention, for example, the apathy of our brother physicians towards the pending bills such as "Health Insurance," "Annual Registration of Physicians," etc., etc. Questions which should be of greatest interest to the welfare of the medical profession are being neglected by the majority of its members; and only a very few of the members of the profession are working their heads off to guard the destinies of our great institution, "the worst underpaid and most unfairly treated laborers in the world."

Southey, the English poet, once observed: "The man is a dupable animal. Quacks in medicine, quacks in religion, and quacks in politics know this, and act upon that knowledge. There is scarcely anyone who may not, like a trout, be taken by tickling." As far as this subject is concerned, at the root of the entire evil, there is first of all the one predominant factor—the ignorance of the masses of the foreign laity.

If we should, for instance, take as an example a Russian peasant, who in his native country lived at some far away village, where in case of illness there could not be found a physician at a distance of a hundred or even a thousand miles, the patient, though he be in the best of circumstances, must appeal for medical aid to some barber or illiterate "healer," midwife, etc. This habit, the trust in the ability of this class of "healers" to assist the sufferers in their distress, these ignorant foreigners have brought to this country. Thus there is nothing surprising in the fact that the various quacks find such a great field for their unscrupulous acts of robbery among the foreign elements of our community.

It is also important to direct our attention to one more important phase of the situation as the foremost factor bringing about quackery in general. Already for over half a century, in every land on the globe, there has been going on a struggle for abolishing prostitution. But very little has been done in this direction. Now, most of the sociologists, studying the different modes of our life, the mutual factors controlling it, have come to the conclusion that the faulty social and economical conditions account for this deplorable situation. The same reasons can safely be ap-

plied to the causes that brought about the institution of prostitution. It has been proven time and again that if there were not the existence of demand, there would not be any necessity for the supply; and in order to eradicate certain evil, it is primarily important to do away with the causes of those evils.

Permit me, in conclusion, to cite one or two more quotations, before we begin our discussion this evening.

Dr. George E. Butler's opinion is that "The masses should be educated and made to understand that the way to do is to patronize a reputable physician. The state and national medical societies should bring out literature in all languages explaining this matter, and successfully fight the organized quack."

The *Journal A. M. A.* has taken the attitude that it is neither the business nor the province of the medical profession to take punitive steps against quackery or the nostrum evil. That is the business of the public officers who are appointed or elected to enforce the laws against swindling, medical or otherwise, in the interests of public health.

Dr. C. F. Taylor, the editor of *The Medical World*, differs from the opinion of Dr. Butler, that "the uprooting of quackery is purely a matter of education because it is a slow process."

"I think," continues Dr. Taylor, "that the best, quickest and most efficient way to rid this country of quackery is through proper laws rigorously executed. I think that every considerable county medical society and every state medical society should have legal counsel; and that the counsel of the organized profession of every state should be kept at the capitol, during every session of the Legislature, to look after the interests of the medical profession and to promote laws against quackery. At other times this legal representative of the state profession should be kept busy in connection with prosecuting attorneys of state and counties, working up cases against quacks, and prosecuting them in the various courts. Until this is done effectively, I feel that quackery will continue to thrive."

It seems, therefore, that first of all, serious attention should be paid to the question of educating the masses. And in view of the fact that the majority of the foreign masses in this country are unable to read the English language, it would be deemed essentially advisable that the Federal, as

well as State and Municipal Governments, should consider it of importance to issue literature in the foreign languages, teaching the foreign population of this country the evil-doings of the various forms and classes of medical quackery. Concerning the licensed physicians who, in their private practice, are using dishonest methods by placing in the foreign newspapers much promising advertisements, different measures will have to be taken. This question can be settled by proper legislation.

While it is quite possible that this will be met by a vigorous protest on the part of the publishers of the various foreign language newspapers, because to them the question of rejection of quack advertisements is a matter of great and important incomes. In connection with this it is safe to say, that if the publishers of most of the foreign language newspapers should have to withdraw the quack advertisements, they might not be able to exist. So that with most of these foreign language newspapers, this is really a question of life and death. Naturally, every attempt to regulate the advertisements with these papers will meet with protest on the part of their publishers.

DISCUSSION

Dr. I. Val. Freedman, as a member of the Committee of the Report, urged the medical profession to continue the study of the question of medical quackery, emphasizing his remarks by the fact that an extensive article about Ancient and Modern Medical Quackery had appeared in one of the recent issues of the magazine of the National Geographical Association.

Dr. B. Gruskin, director, Medical Research Laboratory, related some very interesting experiences from his daily work. In various instances a patient would come with a note from a quack, for the purpose of making a "Wassermann," while such was not by any means indicated at all. As a result, the patient, whether or not it was negative (and in most cases it was negative), would have been treated for syphilis. Thus, he felt, that he somehow placed himself in position of the quack's accomplice. Dr. Gruskin, since that time, does not accept any more work from patients sent by questionable specialists.

Dr. Stubbs, as member of the board of trustees of the Chicago Medical Society, mentioned the attempts of the Chicago Medical Society to participate in the work of eradicating medical quackery. He is in general very skeptical about the progress of this work, although he admits that good work was performed by the Illinois Board of Education and Registration in going after the quacks. In the opinion of Dr. Stubbs, the activities of the director of the Board of Registration and Education are to a great degree due to Dr. Krasnow's calling attention to this evil. Dr. Stubbs

further continued his pessimistic citations of the sentiment of society toward the question discussed: "People who stand very high in our government and industrial life, such as senators, prominent business men, etc., in case of illness, do not even pretend to call for medical assistance on regular physicians, but instead consider it of more benefit to submit to all kinds of prayers of the Christian Scientist cults and other such agencies. Most of the religious publications carry full pages of quack advertisements. It seems, that the task undertaken to stamp out this evil is entirely too great or well nigh impossible, so, what's the use anyway."

* * * As to this problem being by the committee confined to the foreigners only, Dr. Stubbs entirely disagrees: "Quackery is just as widely flourishing among the native Americans. And if this is the case, why not fight the quack on general principles?"

Dr. Schaare: Many of us are negligent in the duties performed in our daily practice, and we do not always take advantage of the newer methods that appear as the progress of medicine keeps on. The quacks take advantage of this fact. Let us by all means strive toward perfection, and the public will in the end be the best judge as to who is the best friend of society. A number of patients from all over the country flock yearly to the Mayo Brothers, because the public has found out that the Mayos are doing good work; this in spite of the fact that there are many others doing just as good work. But the public has found out the work of the Mayos, and is favoring those who made the good reputation.

Dr. Yuska happens to live in close contact with dozens of quacks, and knows that the facts stated in the report are not only true, but are numerous and mildly pictured. Among others, he stated, that within two blocks there are three so-called "drug stores," which in reality are kept by illiterate and ignorant self-styled "doctors"; these quacks are doing a tremendous business. He could keep on endlessly relating facts and incidents from his daily experience, but, what's the use? . . .

Dr. Krasnow, in closing, expressed satisfaction that the medical profession has for a while directed its attention to this much neglected subject, hoping that while there are some of the profession who are skeptical as to what can be done, still much will be attained in the future in the direction of stamping out this great evil. And no matter what difficulties we are confronted with, one gratifying effect of the discussion remains—that there is something somewhere radically wrong in our social-economic structure—that something must be done and kept up in our activities to bring about a better and improved system of affairs.

COMMENT

F. H. Garrison, Lt. Colonel, Medical Corps, U. S. A.: My opinion could not be of much value because I am not engaged in the practice of medicine, and quackery is a practicing physician's problem. I have only attempted to deal with the historical aspects in my book on the "History of Medicine." I think it is a notable fact, however, that unlicensed practitioners usually

flourish best in the more advanced communities, but have a rough time of it in thinly settled places or where the people insist upon having things their own way. In a large city it is difficult to reach criminals or any other social outlaws, and little attempt is made by the population to protect their own interests. I think you have covered the practical aspects of the subject admirably, and I do not believe I could add anything that would be of special value to you for the reasons above given.

A. W. Hedrich, secretary, the American Public Health Association: Needless to say, our Association is heartily in favor of the excellent work which you are carrying on. The amount of time you have already devoted to the subject makes you a very much better judge on the matter than the writer could possibly be. I regret, therefore, that I can offer no specific suggestion.

Dr. Max Thorek, Chicago: The foreign language newspapers have the situation in their palm. It is they who can sound the death-knell to the charlatans, if they so desire, by excluding objectionable advertisements from their columns. In view of the existing political conditions, you are confronted with an almost insurmountable task. However, much can be accomplished by a co-operative plan, in wiping out one of the plague spots of civilization—quackery.

Mary C. Preston, Superintendent, Immigrant's Protective League: It is indeed a most important problem, and I wish it could be brought home to our people, particularly to the foreign population. If prohibition comes in July, the situation will be further complicated until the readjustment can be made and a campaign of education will certainly be needed. I hear that Armour is publishing a paper for their employees, and also understand that the Y. W. C. A. has a Foreign Press Department. Would it be possible for you to interest either of these in your campaign?

Dr. George H. Simmons, Editor, *Journal A. M. A.*: There is no doubt that the campaign of education waged through the Propaganda Department of the *Journal A. M. A.*, and also by a few high class newspapers and magazines, has done much to hamper the trade of the quack and nostrum vendors, so far as the business affects those who can read English. As a result, these gentry have been driven to the foreign-language press and to cater to the large foreign population. The statement in your paper that the exposures of quacks and "patent medicines" that have appeared in the *Journal* have "been limited to the medical literature only, which is not read by the laity," is hardly correct. All of the material that is published in the *Journal* regarding quacks and the nostrum evil, is reprinted by the Propaganda Department in inexpensive pamphlet form and very widely distributed throughout the country. The *Journal* has taken the attitude that it is neither the business nor the province of the medical profession to take punitive steps against quackery or the nostrum evil. That is the business of the public officers who are appointed or elected to enforce the laws against swindling, medical or otherwise, and in the interest of public health. The *Journal* believes

that there is just one rational way of protecting the public against fraud in medicine, and that is by giving the public the facts regarding such frauds as are being perpetrated. This, the *Journal*, has done and is doing. Its work, of course, could be made more far-reaching and would benefit a portion of our population that is peculiarly susceptible to frauds of this kind, if the publishers of foreign language papers would give to their readers the facts which the *Journal* has spent no small amount of money and time to make available.

Dr. A. L. Benedict, Editor, *Buffalo Medical Journal*: Your contention is very true and coincides with the experience here and probably elsewhere. So far as I can make out, the foreigner is a prey of quacks, not because of his nationality, but because he is ignorant. I do not mean that he is ignorant in the general sense, but he does not know the ropes, and lacks the practical acquaintance with conditions in a new country necessary to safeguard his interests along various lines. There ought to be more efficient means to look after his interests and prevent his getting into the hands of medical, real estate, loan and other sharks.

Dr. C. F. Taylor, Editor, *The Medical World*: Long before the *Journal A. M. A.* established its Propaganda for Reform, I began publishing exposures of nostrum in *The Medical World*. I kept this up consistently and persistently; but when the *Journal A. M. A.* took up the work under the able management of Dr. Cramp, I felt that this particular phase of the work was then being done better than I could do it. The large resources of the Association enabled its *Journal* to do this work with great efficiency, which it still continues regularly and persistently. The *Medical World* also continues this phase of the work, but largely now by reproducing quotations and extracts from Dr. Cramp's work. You very aptly call attention to the fact that such exposures in medical publications fail to reach the people who are victimized. That is sadly true, although when I started this work many years ago I hoped to reach the people with this information *through the doctors*; but it has proven to be a slow process. I see that my friend, Dr. George F. Butler, regards the uprooting of quackery "as purely a matter of education." That is also a slow process. I think that the best, quickest and most efficient way to rid the country of quackery is through proper laws rigorously executed. I think that every considerable county medical society and every state society should have legal counsel; that the counsel should be kept at the capitol during every session of the Legislature to look after the interests of the medical profession and to promote laws against quackery. At other times this legal representative of the state profession should be kept busy in connection with the prosecuting attorneys of the state and counties working up cases against quacks and prosecuting them in the courts. Until this is done effectively, I feel that quackery will continue to thrive.

Dr. George L. Servoss, Editor, *Western Medical Times*: The reprints you sent me have been read with interest, but I will be hanged if I know how we

are going to handle the quacks. I usually say, "what's the use," and then proceed to forget all about the matter, for it looks to me as though this class were with us to stay, or until such time as decent people really get together. As secretary of the Washoe County Medical Society, one of my duties is to report illegal practitioners to the proper authorities and endeavor, if possible, to get convictions of such individuals. So far it has been one grand game of "pass the buck" and nothing more. I have about concluded to let things go as they are and allow the Chinese, Chiropractors and other quacks to go on their way rejoicing and "trim" the dear public to their heart's content. One trouble is that the reputable doctors talk too much about quacks. And the quacks like that sort of things, for it is the best and cheapest advertising they can get. When a doctor says anything about a quack the people get an idea into their heads that that doctor is jealous and then too, it gives the quack just that much added publicity. And there is another thing which fosters quackery, and that is the jealousy that one doctor shows toward another. There is little get-together spirit shown within the profession, as a whole. We get in corners as individuals or as cliques, and we use our little hammers vigorously in knocking our brothers who may, or may not, be doing as well or better than ourselves. We go to society meetings and tell each other what good fellows we are and then we go out and give each other the devil. In other words, the medical profession, as a whole, is composed of a very considerable percentage of fools, in that they do not get together and work in conjunction, one with the other. We talk about educating people, but we never send out anything to combat the literature of the quacks, for such things "are not ethical," you know. And there is a whole lot of rot about that thing "ethical." We must preserve a dignified silence and say nothing, lest we be called unethical. The medical profession affects me with an exceeding weariness on many points. It is so exceedingly foolish, you know. I am something of a publicity man and believe I could frame some sort of thing, which would be absolutely ethical, but which would put these quacks forever in the shadow, *and keep them there!* I have suggested something of the sort to some of our local men, but they seemed to think my plan unethical. It is along ethical lines and without advertising any one particular doctor, but something which would show the people, conclusively, that reputable physicians are really preferable to quacks. The idea is this: When a quack rolls into a town and spreads his literature broadcast, let the medical organization combat such literature with that of its own, but along sane and reasonable lines and with an endeavor to show that these quacks are in business for the dollars in it and not because of any superior knowledge or ability and that reputable physicians can do equally good work, if given the opportunity. Just fight fire with fire. Such literature should not bear the imprint of the organization or any man therein. I may be all wrong in this idea, but as a publicity man, it strikes me as something which would

put quacks out of business quicker than anything else. All people are very liable to remember that which they see last longer than that which first came before them, and if the quack's literature were followed by something decent, then the doctors would reap the benefit. Mind you, there should be no mention of the quack in such literature. No abuse, praise or any other mention, for such would be publicity for the quack and would defeat the purposes the profession desired to attain. We can talk and talk until we are black in our faces, about these gentlemen and they will still live, for they know now, when and where to use printer's ink. Not only that, but they "put up a front" and look prosperous and that has a mighty good dollar-getting effect. In fact, primarily they are advertisers and they know how to advertise to the best advantage. And they also know that organized medicine, as it stands today, carries but little respect from the masses. And they use that fact to their own good advantage. When we rid organized medicine of its present autocratic government and make things really democratic, so that you, and I, and all other privates in the rear ranks can obtain a fair and square deal, and we get rid of our blood suckers, then may we hold up our heads and fight like men. But just so long as we submit to the sort of things that have been handed out to us for these many years, just so long may we expect conditions to go on as they have. I am openly fighting the clique now in command of medicine, and I do not care a continental who knows it. A few of us, as Roosevelt said, "have the guts" to stand up and assert ourselves for right, justice and fairness in the medical ranks. *And just that sort of thing is going to obtain.* I believe in ethics, but it should be the same sort for every one and no favors shown to a choice few. You may consider me a medical anarchist, and perhaps I am, but I am not in favor of keeping a lot of men "not in practice" in command of things, that they may thrive upon the things which come from the rank and file, who are working day and night for sustenance.

Editorial, *American Journal of Clinical Medicine*: In his paper, Dr. Krasnow calls attention to the fact that our foreign-born citizens were being exploited by the advertising medical quacks. It is said that the creed of this unscrupulous gentry is brief and to the point—"Scare the patient out of his senses, find out how much money he has, then get it." Our foreign-born citizens come to us from paternal governments, and the fact that a man is permitted to advertise in the public press as a doctor gives him and his statements an official status in their eyes. They are, therefore, easy victims. This class of advertisers, fortunately, has been, largely, driven out of our own newspapers, but they still find a lucrative field among the readers of the periodicals published in foreign languages, and it is exceedingly difficult to deal effectively with this evil. Just now, one of the Chicago papers is raiding the advertising quacks, with the promise of excellent results. Unfortunately, the raid is an occasional measure, while the activity of the quacks knows no intermission. The wisdom of permitting news-

papers and other periodicals to be published in any but the English language has been questioned. However, they are the only means which these people have of acquainting themselves with the trend of affairs. They might, indeed, be made a valuable means of educating the foreign-born citizens in English, were all such publications required to print all their contents in parallel columns, one being English. Unfortunately, almost insurmountable financial considerations stand in the way of such a plan—unless by government subsidy. It is not possible to forbid medical advertising by law. Some of these advertisements are so astutely worded as to be unobjectionable in a legal sense. While objection may be made to anyone claiming to "cure" cancer, tuberculosis, "Bright's disease," and diabetes, we cannot object if his sole claim is that he is *treating* these diseases. It might be well if medical societies were to carry in each of these papers a standing advertisement from the Chicago Medical Society, to the effect that American physicians of good standing do not advertise in the public press and that persons who do thus advertise are not received as members of the professional bodies or recognized as belonging to the profession. If anyone has a better suggestion to make in the way of meeting this difficulty, we shall be glad to hear of it.

Dr. Hugh N. MacKechnie, Secretary, Chicago Medical Society: The quack problem is not an easy one of solution. With the ignorant, unsuspecting foreigner and the easy-going American as subjects to work on, a quack has little difficulty in applying his nefarious business. The work which has been done by various societies and newspapers in enlightening these people is cutting down their material profit, and now that you are taking it up and presenting it to many of the editors of foreign papers, besides presenting it to the medical societies, it is hoped that the medical profession will awake to the possibility of eradicating these rascals. We know that it is the duty of the state to protect these people. We also know that our public officials have much work to do and that which is most urgently presented receives the earlier consideration. As a profession, we should do our part in aiding these officials and in urging them to do their duty. Chicago's motto is "I will"; let Chicagoans adopt it!

ROBT. JONES OPERATION FOR TALIPES EQUINO VARUS.*

LUCIUS H. ZEUCH, M. D.

CHICAGO

Gentlemen of the North-West Branch, I bring to you this evening a paper upon the shortening of the extensor proprius hallucis tendon by means of transplantation into the first metatarsal bone, for talipes equino-varus, with demonstration of a case, in which this procedure was successfully

performed. The earliest record I have been able to find on this subject was in 1903 when Dr. Robt. Jones of Liverpool, England, in collaboration with Dr. Tunny, also of that city, published a monograph upon the correction of deformities due to infantile paralysis. Six years ago I think

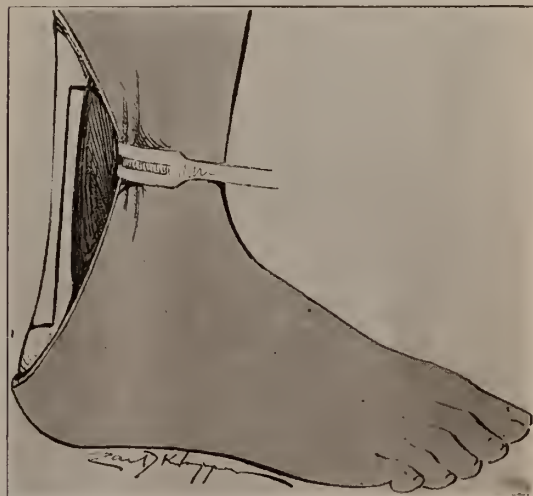


Fig. 1. Incision for lengthening the tendo Achillis.

it was, more elaborate operations were described and illustrated by means of *Stereo-Clinics* edited by Dr. Howard Kelly of Baltimore, transplanting tendons and muscles for the correction of

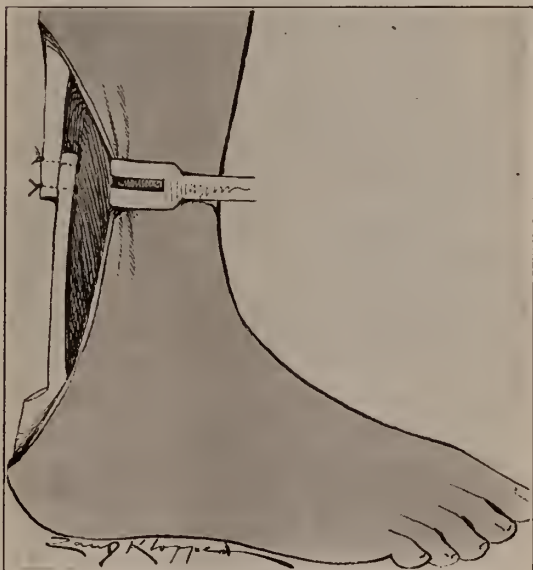


Fig. 2. United cut ends.

paralytic deformities. It is from this collection that I was able to perform the operation I am to

*Read before the North West Branch of Chicago Medical Society, March 14, 1919.



Fig. 3. Exposure of the extensor proprius hallucis tendon.

describe to you tonight. The indications for this operation are as follows:

1. Slight to moderate degree of claw foot due to transient palsy of the short flexor muscles of the foot.
2. Talipes equino-varus with marked inversion of the foot.
3. Foot drop due to infantile paralysis.

For the marked contraction of the tendo achillis which accompanies all of these deformities Dr. Jones advises subcutaneous tenotomy performed in the following manner. A curved bistury is inserted behind the tendon and with a sawing motion the tendon is partially divided and extension of the foot is accomplished by forcible stretching with a specially constructed wrench.

1. The objections to this method are a resultant weak tendon which may ultimately again contract.
2. A possible complete severing of the tendon in the hands of a nervous operator necessitating extensive repair by means of the Czerny method, with doubtful end results.

3. A possible severing of the posterior tibial artery; not a great calamity, for the anterior tibial artery would take up the function of the destroyed artery.

But the resulting hematoma might ultimately infect, leaving an ugly sloughing wound.

I believe the open method of elongating of the tendon is far preferable. In the case I present to you this evening the Anderson method was employed on both feet. This procedure is as follows: An incision is made longitudinally the entire length of the tendon which is exposed and separated from its substructures by means of a spatula. The sheath is slit up and the tendon divided its entire length from its lateral aspect. The external segment is severed at its insertion into the os calcis. The internal segment is severed where it begins to enlarge into the soleus and gastrocnemius muscles. The cut ends are now united by means of chromic catgut sutures. There is now left an over elongated tendon but the subsequent contraction of the muscles more than takes up this excess. Even with this elongation constant vigilance is necessary lest a contracture again result. The sheath is now sutured together and the skin coapted. The disadvan-

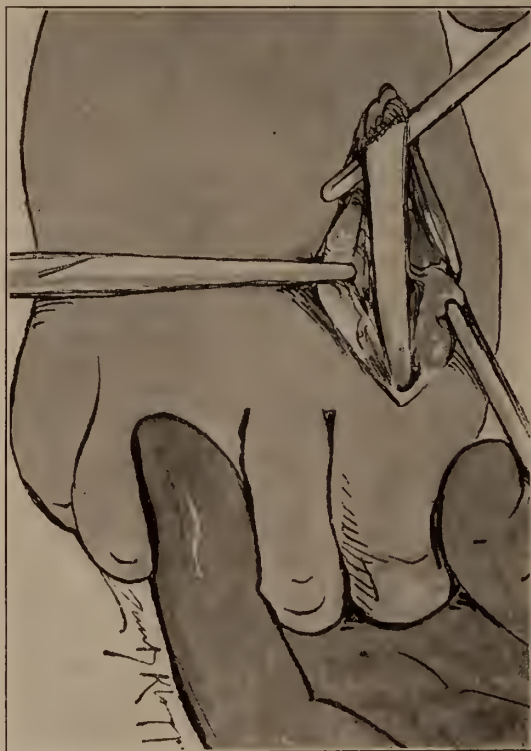


Fig. 4. Separating the tendon from substructures.



Fig. 5. Severing the hallux tendon at its insertion.

tage of this method is that infection around the tendon may possibly cause failure of union which would necessitate subsequent operations with doubtful results. This calamity happily did not obtain in either foot of the child I present to you tonight. While this operation relieves the flexion of the foot it does not aid the extreme inversion of the foot. To accomplish this Dr. Jones shortens the extensor proprius hallucis tendon. Now as you remember this muscle gets its origin from the anterior $\frac{2}{4}$ of the fibula and interosseous membrane, it passes through a separate compartment in the annular ligament and is inserted into the first phalanx of the great toe. From its ability to pull from within—outward it tends to keep the foot in a horizontal position, in proper alignment. Now as this tendon is over stretched in talipes equino varus shortening of this muscle will bring the foot upward and outward.

Let us now see how this is accomplished by

Dr. Jones. An incision is made about two inches in length over the tendon of the extensor proprius hallucis near its insertion. The tendon exposed, it is separated from its substructures by means of a spatula. A clamp is put on the distal end and while the toe is in extreme extension, it is severed at its insertion into the first phalanx of the great toe. This frees about $1\frac{1}{2}$ inch of tendon. Because of the small calibre of the tendon the sheath is allowed to remain intact. Through the distal clamped end a long catgut suture is inserted with a long straight needle. The structures over the head of the first metatarsal bone are now dissected away and the periosteum split up and retracted from the head of the bone. At this time a counter incision about $\frac{3}{4}$ inch is made in the plantar surface of the foot, the plantar fascia is divided, the substructures dissected aside, the periosteum again retracted from the head of the plantar surface of the bone and a hole drilled through the head of the bone sufficiently large to permit the passage of the threaded tendon through the tunnel. The tendon is now sutured to the plantar fascia and the skin wound closed. To reinforce this union a suture is passed through the periosteum, tendon and periosteum opposite on the dorsum of the



Fig. 6. Drilling the metatarsal bone,

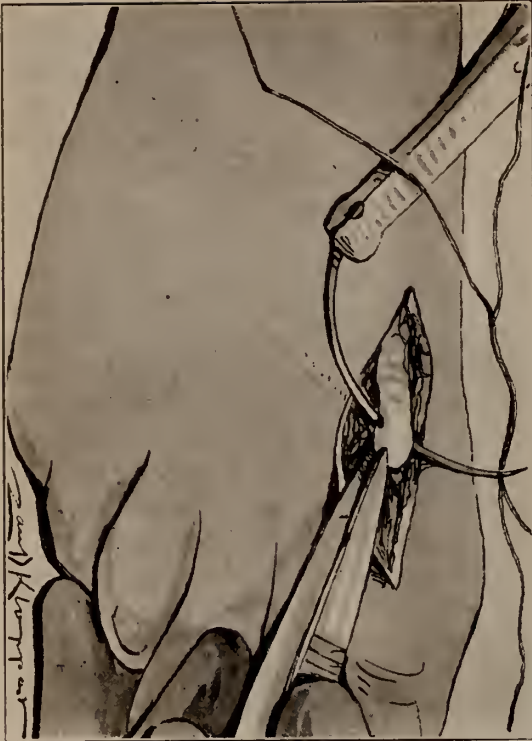


Fig. 7. Threading the distal end of hallucis tendon.

foot and the skin wound closed. Dr. Jones reinforces the extension of the foot in some cases by means of an ellipsoid of skin, dissected



Fig. 8. Passing suture through tunnel.

from the dorsum of the foot extending to the external malleolus and uniting the skin edges. This is of only temporary value as the skin soon stretches again. This expediency was not employed in my case as it was unnecessary. Now as to the disadvantages of this operation. Because of the severing of the opponent of the flexors of the great toe, it naturally becomes superflexed and voluntary extension is impossible. This defect is partially compensated for by the hallux tendon of the extensor brevis digitorum which as you know is also inserted into the first phalanx of the great toe. Aside from some difficulty in applying shoes there is no ill



Fig. 9. Passing the tendon to the plantar surface.

effect from this deformity. The end results from these operative procedures are all that can be reasonably expected in view of the fact that these patients are usually hopeless cripples before operative interferences.

Now as to the after treatment, the foot is extended upward and outward in over correction by means of a cast. Windows are cut in the cast over the places of incision and it is allowed to remain three weeks after which gentle massage is instituted. However, the cast is replaced daily until a firm union results and the possibility of contractions are passed. The patient is encouraged to walk after six weeks and if any tendency



Fig. 10. Tendon in new position.

to inversion of the foot follows, a brace is procured until this fault is corrected.

There is some question as to the etiology of the deformities in the child I am presenting to you this evening, for whose double talipes equinovarius I operated about two and a half years ago. I am inclined to regard her case as congenital, although the mother claims the deformities were of gradual onset. Whether infantile paralysis of the peronei muscles or "Little's disease" was



Fig. 11. Reinforcing tendon.

the cause—though I have not been able to get a clear history of sickness that would lead me to assign either malady as the primary cause—or her deformities were congenital with gradual spastic contraction is of little moment as far as the case in question is concerned, for the end results justify the means of correction. Up until six years of age she had never walked. She made attempts at standing on her toes and the faulty position she assumed in these attempts resulted in the habit she now has of a somewhat shuffling gait. All manner of appliances, massage treatments and forcible stretchings availed her nothing and at six years of age she still had to be carried about like a baby. The atrophy from disuse of the muscles was marked. The marked contraction of the tendo achillis and decided inversion of



Fig. 12. Close-up view showing hammer toes.

the feet made those consulted wary of employing the old method of tenotomy. Unfortunately these bad prognoses made the family consult many, before they submitted to correction by the "Jones Method." At this time I became interested in the *Stereo Clinics* showing this method of correction of these defects and I asked permission to try the operation on one foot. With misgivings the parents decided to take a chance because of the pleadings of the child, whose desire to walk had almost become a passion. She then entered St. Elizabeth's Hospital and the right foot was operated upon. The foot operated on showing such a contrast to the deformed foot, I had no difficulty in persuading the parents to allow correction of the other foot, within a week. Unfor-

tunately I did not take pictures of the deformities before operation as my main thought was relieving the patient. At that time I had no thought of publishing the results or presenting her to a scientific body, hence my inability to give you the usual before and after illustrations. However, I can give you an illustration of the final results showing her standing without supports. While she will never walk normally she shows sufficient power of locomotion to make her useful and independent of artificial supports, a constant living tribute to the skill of that great reconstructive surgeon, Dr. Robt. Jones.



Fig. 13. Child standing without support.

The discussion following the reading of this paper was both interesting and instructive. Dr. Ferdinand Pirnat emphasized the necessity of over lengthening the tendo achillis because of the spasticity of the muscles attendant upon these conditions. Dr. Svenning Dahl dwelt upon deformities of bones often associated with talipes equino varus and methods of correction of these defects.

I am indebted to the Southworth Co. of Troy, New York, for permission to give illustrations of the steps in transplantation of the tendon of the extensor proprius hallucis.

3014 Fullerton Avenue.

EXTRA-UTERINE PREGNANCY.*

F. F. WISNIEWSKI, M. D.

CHICAGO.

A fertilized ovum can be arrested anywhere in its course from the ovary to the uterus and undergo development there, thus giving rise to an extra-uterine pregnancy. The term "Ectopic" is used somewhat more widely and includes cases in which the ovum undergoes development in some abnormal diverticulum of the uterus itself.

Extra-uterine pregnancy mostly occurs in the tube. A pregnancy developing in the ovary is rare. About seventy such cases are recorded. In the tube the development may be intramural, isthmic or ampullar, according to position. It may be unilateral or bilateral. It may be a "twin" pregnancy, both ova being developed in the same tube; or the double pregnancy may be in both the tubes. The time of fecundation of the ova in a double ectopic pregnancy may be simultaneous or may be separated by a long interval. Heineck collected 89 cases of double recurrent and bilateral tubal pregnancy in the literature from 1908 to 1916, inclusive. Moreover an intra- and extra-uterine pregnancy may develop at the same time.

The condition has long been known. Abulcasis referred to it in the tenth century, and Riolan reported it in 1626. There is no satisfactory etiology for the condition of extra-uterine pregnancy. Many causes have been assigned, viz.: salpingitis, pelvic adhesions, diverticula and accessory tubes, disease of corpus luteum, etc. I personally maintain that a low powered fertilized ovum too weak to pass along the remainder of the tube to the uterus is a strong etiologic factor in extra-uterine pregnancy; however, none satisfy. Oastler, in 106 cases, treated in a number of years in the New York hospitals, found that in two-thirds of the cases there was nothing that could be assigned as a reason for the condition. It may occur in a primipara or a multipara. But it is more often observed after a period of relative sterility. Thus, Taylor, in the Roosevelt Hospital, New York, found that in 25 per cent of his cases there was a period of sterility for five years before. While a great many of these patients have had previous inflammatory conditions in the genitalia, many cases occur without any such

*Read before the Polish Medical Society, May 31, 1918.

Read before North-West Branch, Chicago Medical, March 14, 1919.

history. Foskett of Bellevue Hospital, New York, studied 117 cases of ectopic gestation. He found that only 17 gave a definite history of gonorrhea; 4 had syphilis; 30 had been pregnant before; 52 had children at term only; 32 had children at term and abortions. Thus nearly one-third had abortions, and the writer seems to think that this may be a contributing cause.

In my own experience of 6 cases of which pathological examinations have been made:

One had fibromata of uterus and had two normal deliveries previously.

Two gave positive history of gonorrhea and sterility.

Two had chronic endometritis, thus rendering poor soil for fertilization in the uterus proper, and in one no specific pathology could be found.

Extra-uterine pregnancy may present itself to the physician in one of two clinical forms—the unruptured and the ruptured—with careful examination there should be no great difficulty in diagnosis; but probably half of such patients are submitted to treatment for other conditions.

In unruptured tubal pregnancy the usual signs are: amenorrhea or irregular menstruation; the patient's suspicion that she is pregnant; pain of a colicky, intermittent nature, due either to distention of the tube by hemorrhage from eroding villi, or from uterine hemorrhage, the result of decidual degeneration or disintegration; a distended tube may be palpated on one or other side. The *negative* signs are that in unruptured tubal pregnancy there is usually no rise in temperature. Ladinski says that in intra-uterine pregnancy after the fifth week there is an *elastic area* invariably present in the median line of the anterior wall of the body of the uterus. This is not observed in tubal pregnancy.

In ruptured tubal pregnancy the principal classical symptoms are: abdominal pain, sudden pallor, and collapse.

The pain felt by a patient with unruptured tubal pregnancy is usually the symptom which compels her to seek advice. It is short, quick and stabbing in character. The pain is pelvic, but the patient may refer it to the back or kidney region. There is a history of continuous or intermittent slight hemorrhages and irregularities of menstruation. In some cases the pain is acute, violent and with comparatively quiet intervals between attacks. In the other cases it is sub-acute

and crampy. In the first type there is excessive hemorrhage. In the second the hemorrhage is not so severe but is more or less continuous. In 106 cases reported by Oastler 15 were of the first type and 91 of the second variety.

There is usually very little doubt in the case of ruptured tubal pregnancy except that the condition may be mistaken for some type of pelvic inflammatory disease. In such conditions a blood count is of value. A relatively high leucocytosis (usually above 20,000) and polynuclears varying from 80 to 90 per cent. point to an ectopic pregnancy. Foskett has found this so in his study of 117 cases and it has also been noted by Oastler. The latter says: "In many severe cases the noticeable symptoms were a considerable rise in temperature, rapid pulse, low red cell count, high white cells, and polynuclear increase."

In differentiating between an ectopic pregnancy and inflammatory pelvic disease two conditions should be specially noted. Inflammation usually tends to pull the uterus into a retro-position. In ectopic pregnancy it is usually in a forward position. Secondly, the excessive tenderness in ectopic pregnancy on bimanual examination of one or other side of the pelvis out of all proportion to the rigidity or distention of the abdomen.

Foskett, in cases of doubtful diagnosis, recommends a posterior vaginal section. Free blood will usually be found in the peritoneal cavity if the case is an ectopic pregnancy. Ladinski, however, says this method is uncalled for and unsurgical.

An ectopic pregnancy is often confounded with gall bladder disease, ovarian cyst, with a twisted pedicle, pyosalpinx, hydro-salpinx, salpingitis, and perforated uterus.

In addition to the elastic area about the median line already referred to, Lascano mentions that in an ectopic gestation there is a peculiar soft elastic resistance in the region of the tumor which marks the site of the insertion of the placenta. The normal placenta gives a spongy feel on palpation, but in an ectopic it is much more marked.

The Evolution of an Extra-Uterine Pregnancy Varies. The most common occurrence is tubal abortion or tube rupture at the end of about six weeks. Pregnancies older than three months are uncommon. Abortion usually occurs by erosion of the tube wall rather than by rupture of the tube through distention. The sac ruptures

through the wall either into the abdomen or into the broad ligament.

There are different eventualities after rupture, viz.:

a. The fetus may continue to develop in the abdomen and become an abdominal pregnancy.

b. The fetus may die and become absorbed or become a fetus cyst, and as such may give rise to many complications.

c. The fetus may continue to develop for a time and then die, in which case it undergoes either putrefaction, mummification, maceration or becomes a litho-pedion. (A calcareous infiltration of retained fetus.)

When the rupture takes place into the broad ligament and the fetus continues to develop there is an intra-ligamentary or tubo-abdominal pregnancy.

But rupture in the tube does not always occur. Barrionnevo reported a case in which the left tube was sufficiently developed to hold a full term fetus and to retain it for four months longer than term without rupturing. In other cases the pregnancy has evolved to term with a living child. Such children, however, are usually deformed and die young.

Consensus of opinion seems to be in favor of early operative treatment in ectopic pregnancy.

In pointing out the operative treatment, several clinical classes must be considered, viz.: 1, before rupture; 2, hematocele; 3, repeated moderate intraperitoneal hemorrhage; 4, profuse intraperitoneal hemorrhage; 5, hematoma, and 6, advanced cases.

1. *Before Rupture*: The only safe plan of treatment in this stage is abdominal section and removal of the pregnant tube as soon as diagnosis is fairly certain. The patient is in constant danger of a sudden serious hemorrhage, hence, for that reason, the sooner she is operated on the better.

2. *Pelvic Hematocele*: In such a case it is well to watch the patient for a while, in the meantime keeping her quiet in bed. In the course of a week or ten days there will be decided improvement, showing that nature is taking care of the blood and exudate, and that the patient will probably recover without operation or else there will be renewed evidence of irritation, showing that the embryo and membranes are still growing or that the blood and exudate are acting as a persistent source of irritation. When there

is persistent irritation after this period of rest operation is indicated.

3. *Repeated Moderate Intraperitoneal Hemorrhage*: This class comprises the majority of cases of tubal pregnancy. The treatment for such cases is abdominal section as soon as diagnosis is clear. The technique is in general the same as for salpingitis with exudate. If the ovary is badly damaged it is removed along with the damaged tube.

4. *Profuse Intraperitoneal Hemorrhage*: In these cases immediate abdominal section is advisable.

5. *Pelvic Hematoma*: If there is any evidence of active or recurring hemorrhage the preferable treatment is abdominal section, with removal of the damaged tube and the blood mass in the broad ligament. If there is simply a quiescent blood collection in the connective tissue, keep the patient quiet and watch. If the mass remains stationary and symptoms of pronounced irritation persist or arise later the patient should be subjected to operation, abdominal or vaginal, as indicated by the location of the mass and the accompanying symptoms.

6. *Advanced Cases*: These cases vary so much that it is impossible to give a rule applicable to all. In some of them immediate operation is indicated. In other cases it is advisable to wait for a time, either because the child only recently died and the placenta and adhesions are still dangerously vascular, or, in rare cases, there is good reason to hope for saving the child alive without unjustifiable risk to the mother.

In ruptured cases after extensive hemorrhage the operation is usually confined to excision of the appendage bearing the gestation sac. Such patients, even in a state of acute anemia and a rapid pulse, stand operation very well and much better than other classes of patients with equal blood pressure and pulse findings. Where the state of the patient allows a more extensive operation the remaining tube or the uterus may be removed to prevent recurrences. Statistics show that a woman who has had one ectopic pregnancy runs a good chance of another.

When operation is done with a living fetus it is best on account of hemorrhage to remove the fetus but to leave the placenta until it has had time to become separated from the maternal circulation. There is greater conservatism at the

present time regarding preservation of the uterus and remaining tube.

In Foskett's 117 cases at the Bellevue Hospital, New York, hysterectomy was done six times in the first series of 22 cases, whereas it was only done in two cases of the remainder.

Most operators now recommend the abdominal route in operating. Even when the diagnosis is doubtful between an ectopic pregnancy and a pelvic inflammation this route will fulfill either indication. Laparotomy is the only method by which the hemorrhage occurring from rupture can be safely arrested. A colpotomy (vaginal route) will not arrest hemorrhage and may even re-awaken it.

In many exsanguinated cases a blood transfusion may be necessary. The citrated blood transfusion method of Lewisohn is best for this purpose.

The prognosis of operations for extra-uterine pregnancy is singularly good. With ordinary precautions it does not exceed 2 per cent. mortality, and in the hands of competent surgeons it is almost nil. The after results are in general most satisfactory.

On the other hand, Schanta found 75 recoveries and 166 deaths in 241 cases treated expectantly.

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THE CLINICAL ASPECT OF THE DIAGNOSIS OF DISEASES OF THE ALIMENTARY TRACT.

A. A. GOLDSMITH, M. D.
CHICAGO.

My purpose tonight is to avoid all stereotyped discussion of the diseases under consideration; instead I will endeavor to point out a few things which to me appear especially important, and which are perhaps not given due emphasis in the

ordinary text-books. In regard to the stomach, I think that we can safely say from a practical standpoint that we have three diseases; namely, ulcer, carcinoma and syphilis. While I will not deny that one meets occasionally with a case of chronic gastritis, this disease corresponds in its rarity to such a lesion as an organic tricuspid leak in the heart. During my student and interne days we never diagnosed ulcer except in the presence of hemorrhage, and I need not tell you that in the light of our present knowledge, only few of our cases of ulcer are accompanied by visible loss of blood. In those days these cases were practically always diagnosed as chronic gastritis. Another large group of cases formerly diagnosed as chronic gastritis we are now finding out are cases of chronic appendicitis, gall bladder disease or pelvic disease, with gastric symptoms. These errors, however, lead to no serious consequences.

It is probably unnecessary to warn you against the danger of mistaking a pulmonary tuberculosis for a stomach condition. These cases often resemble gastric ulcer, not alone in their symptomatology, but also in their laboratory findings, and one can readily see that if these patients are put on the limited diet of ulcer treatment the lack of proper nourishment allows the tuberculosis to advance. For a long time I wondered why so many tuberculous patients had gastric symptoms, and it occurred to me it might be explained by the fact that the vagus nerve supplies both the lungs and the stomach. I remember years ago that when I was willing to take such miserable tasting mixtures of the ammonium chloride or carbonate type, that the minute the medicine reached the stomach I had the sensation of the drug having reached the bronchial tubes. This would seemingly be explained in the fact that the vagus ends in the stomach being irritated, the sensation was perceived in some reflex manner by the more irritated and sensitive ends in the bronchial tube. It occurred to me that the converse might be true in regard to pulmonary tuberculosis; the nerve ending in the bronchi being irritated, these irritations were transmitted to the terminations in the stomach. These patients often have very little or no cough; or if they have a cough they endeavor to conceal it. We should not be so confident in our diagnostic methods as to believe that we can detect an early tuberculosis. It is not necessary to point out to you the value of the x-ray in assisting in

the diagnosis of cases exhibiting few or no diagnostic signs.

Gastric Ulcer is now standing upon such a firm clinical foundation that I will not belittle your intelligence by discussing it except that I would like to touch upon one of its complications; namely, pyloric stenosis with dilatation. The stomach may become so large and so atonic that it fills the entire abdomen and on examination one is able to elicit the findings of free fluid in the peritoneal cavity, whereas in reality the fluid is in the greatly dilated stomach. A few years ago one of these patients presented himself at the Post Graduate Dispensary, and we were at the point of inserting the trocar to remove the abdominal fluid, when it occurred to me that it would be a good plan to insert the stomach tube, and we withdrew from the stomach a large amount of material containing sarcinae. I recalled then then I had read in text-books that the stomach had been tapped when the operator thought he was putting the trocar into the peritoneal cavity. Up to that time it was impossible for me to understand how such an error could be made.

Before leaving the subject of ulcer I wish to say that sometimes the late pain of duodenal ulceration is simulated by other conditions. To illustrate this I will mention a case forty-five years of age who came in complaining of stomach trouble for six months, the symptoms being chiefly pain and pressure in the epigastrium, and he complained in particular that the attacks seldom occurred in the day, but usually at twelve or one o'clock at night. On this history, and finding blood in the stools, in spite of the somewhat low gastric acidity, duodenal ulcer was diagnosed; the operation disclosed a large carcinoma of the lesser curvature adherent to the liver. It seems that the interpretation of the late pain might be as follows: The fundus of the stomach undergoes active contraction only during the hunger stage. In this particular patient these contractions pulled upon the adhesions to the liver and caused the pain.

In regard to *cancer* of the stomach there is not much to be said. The various refined methods of laboratory diagnosis brought out from time to time have not been of much diagnostic help. A few years ago I was under the impression that the gastroscope might help in arriving at an early

diagnosis. One of these instruments was procured and employed in a moderate number of cases without its ever having given any material help. Furthermore, the use of the instrument was fraught with danger. One patient, after its use, vomited two quarts of blood. So many authorities, and especially the Mayo Clinic, contend that the majority of cancers of the stomach develop on an ulcer base. This is certainly not confirmed by my experience; in fact, the majority of my cancer patients have told me that up to the time of the onset of the symptoms for which they seek relief they had no stomach symptoms.

Syphilis of the stomach is a disease far more common than we have previously believed. Its symptomatology is rather indefinite. The patient complains of varying degrees of distress usually without very severe pain. This distress is apt to bear no distinct relationship to meals; at least there is no such distinct relationship as pertains to ulcer. The gastric analysis shows a very low or absent acidity, and some of these patients show a cachexia which would do credit to an advanced cancer. The x-ray picture varies, depending on whether we have a gumma, thus resembling a carcinoma, or whether we have merely diffuse infiltration of the wall, making the stomach very stiff, and leading to the so-called "leather bottle" appearance. In this case the opaque meal leaves the stomach extremely rapidly and sometimes in a few minutes after taking the meal the stomach is almost or entirely empty. Four years ago such a patient entered Wesley Memorial Hospital, and although he was a young man, from his appearance, he was judged to have cancer. Through an error a Wassermann was made on him instead of on the man next to him in the ward, and this turned out to be strongly positive, and this patient, brought in to die, left the hospital in about two weeks. It seems very probable that many of the cases we are seeing today who were told by their physicians twenty or thirty years ago that they were dying of cancer have recovered from a syphilitic stomach. At any rate, it behooves one not to boast about having been cured of a cancer of the stomach.

While speaking of syphilis, it will not be out of place to mention those cases who very suddenly develop severe pain in the epigastrium resembling a perforated gastric ulcer and in whom we also have a four plus Wassermann, followed by an excellent therapeutic result. If the time

were not short I might mention a few of these cases.

In gall stone disease many cases run their course with complete absence of colic. I need not remind you that jaundice is the exception. As mentioned above, many of these cases suffer from dyspepsia. The gastric analysis in these cases may show achylia, normal acidity, or an increased amount of acid. Also, it is quite common for a patient suffering from gall stones to develop acute pyloric spasm, especially at night. These attacks are commonly called acute indigestion, and I can very well recall in the early days of my medical work that no idea was entertained that there was any relationship between these attacks and the gall bladder. You have probably noticed that the patient is tender over the stomach and not in the region of the gall bladder. When the attack passes off either spontaneously or under the effect of a hypodermic, it is then possible to elicit tenderness in the right hypochondrium.

In regard to the pancreas there is one physical sign often overlooked in malignancy of this organ; that is the presence of a systolic bruit. Although this sign is not pathognomonic of this condition, it is nevertheless extremely suggestive. A few years ago at Wesley Hospital a woman entered with pain of rather indefinite nature in the upper abdomen on the right side and upon operation nothing was found except a Jackson's membrane, in spite of the fact that the examination had disclosed a murmur in the epigastrium systolic in time. She returned to the hospital in a few months with a large mass in the upper abdomen a little to the right and a second laparotomy disclosed a carcinoma of the pancreas. A second case illustrating this point is a man about sixty years of age who came to the Post Graduate Hospital with a deep jaundice and a history that the jaundice came on after what appeared to have been a typical colic. The examination showed a palpable gall bladder and a bruit systolic as to time and a little to the right of the median line. The history was so typical of gall stone disease that this condition was diagnosed in spite of the large gall bladder in the presence of jaundice and in spite of the bruit. The operation showed the patient to have a carcinoma at the head of the pancreas.

I would like to take occasion at this time also to urge you to auscultate the abdomen in all obscure cases. It often helps in the localization of obstruction of the bowel. A few years ago a case was seen in which a physician had under observation an aged woman who had been vomiting for two days. Examination showed nothing except that the intestines were moving very little on auscultation, and just above the pubis was heard a gurgling of gas and air. Inquiry then led to the information that the woman had a complete prolapse of the uterus which for two days she had not been able to replace. Apparently the descending organ had taken with it a loop of gut. The replacement of the uterus removed all obstructive symptoms.

In considering the diseases of the intestinal tract I will take up only a few minutes of your time. You all know that achylia gastrica is frequently accompanied by diarrhea. Although this increased frequency of stool may be distributed throughout the day, it is not uncommon to have it occur in the early part of the day only. These patients sometimes complain that they are awakened in the morning by a colic and that after having three or four evacuations they are through for the day. It would seem that the diarrhea occurs at that time of day when the large amount of food from the evening dinner of the previous day is in the descending colon.

Carcinoma of the rectum is often very elusive. I need scarcely tell you that carcinoma, *per se*, is not at all painful. In the internal organs it becomes painful only when some orifice (such as the pylorus, cardia or anus) is involved or in those cases in which we have the peritoneum encroached on. This readily explains, therefore, the fact that a cancer occurring in the ampulla of the rectum (the usual location) may be entirely painless. Also, the patient may have no history of passing blood or mucus and for a long time he may have no obstructive symptoms. There is fresh in my memory a case a physician had had under his observation for a number of months, a relative, who complained chiefly of distress after eating. There was no pain in the rectum. In the course of the routine examination a large cancer was found, which, although removed, caused death by recurrence six months later.

CASE OF BILATERAL (DOUBLE) SPONTANEOUS PNEUMO-THORAX.

ETHAN A. GRAY, M. D.

CHICAGO.

Medical Superintendent, Chicago Fresh Air Hospital,

Mr. C. M. O.—32 years of age, traveling salesman. Has had symptoms of and been desultorily treated for pulmonary tuberculosis for the previous year. Had been constantly engaged in business until May 20, 1918, when he consulted a physician in regard to his somewhat troublesome cough. A sedative cough mixture was prescribed at that time.

On the night of May 24 a violent coughing spell was marked by a sudden pain in the right side, followed shortly by dyspnea. Physicians who were called made the diagnosis of spontaneous pneumothorax, right.

The writer was called at 1:30 p. m. the next day (May 25), the patient was found to be cyanotic, dull and dyspneic, pulse 130, respiration 46, temperature 103. Examination confirmed the previous diagnosis and also disclosed much pathology in the left lung, viz.: cavitation of the upper lobe, together with much cicatrization; over the whole left lung were found rhonchi and crackling rales.

Aspiration of the right chest was immediately done and 2000cc. of air withdrawn; the patient promptly rallied and became comfortable.

He was removed the same afternoon to Chicago Fresh Air Hospital, where, ten hours later, it became necessary again to aspirate. The escape of air from the lung increased and it was soon found necessary to aspirate at shorter intervals. To facilitate this proceeding a needle was left in situ. A tube, connecting it with a siphon water bottle, made it a simple matter for the supervising nurse or intern to withdraw air without making frequent punctures.

Bearing in mind the extensive disease of the left lung, it was felt that the latter did not contain enough aerating tissue to sustain life. Nevertheless, to determine the point, the trocar was allowed to remain open in the chest wall on the pneumothorax side, creating, in effect, an open pneumothorax. Within a very few minutes the patient showed great distress and aspiration was done.

As was to have been expected, effusion soon appeared and this, in a short time showed infection. Tubercle bacilli, streptococci, pneumococci and other flora were recognized on the slide. The amount of fluid soon became great and required frequent aspiration. Air began to diminish in quantity. On the fourteenth day a fistula occurred in a needle track. The skin opening was fortunately trapped and, while coughing, expelled air and fluid (pus and sero pus), there was no inhalation through the sinus.

It was now decided to attempt to bring the lung down; to this end, continuous siphon drainage was established, with the result that, by June 18 (on the 23rd day) breath sounds were heard over the right upper lobe as far down as the third rib, and respiration became much easier and patient was able to lie on the pneumothorax side.

During this entire period (up to this point) the temperature ranged from 101 to 103, pulse averaged 120, respirations 36. Appetite was fair but variable.

On the seventh day an extensive emphysema occurred and involved the chest, abdomen, scrotum, penis, neck and face. A free opening was made through the skin, down through the needle track, which stopped further spread and permitted of much deflation, demonstrated by the escape of air bubbles, from time to time.

June 19 the patient complained of shortness of breath; aspiration of the right chest was done, but little relief was afforded. The trocar found the base of the lung in the fourth space. Examination of the left lung showed diminution of breath sounds. June 20 the patient was found to be much worse. While fair respiration was being performed by the right lung, the left lung presented no sounds whatever. The patient complained of some pain in the left lung, but of very little dyspnea.

Aspiration of the left chest relieved the patient of 1800cc. air, but did not improve the general condition. He was comfortable until his death, which occurred 24 hours after the second rupture. Unfortunately for the patient, the lung first damaged happened to be the lung alone capable of sustaining life.

No autopsy permitted.

2733 North Clark street.

ILLINOIS MEDICAL JOURNAL

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State society will pay no bills for legal services except those contracted by the Committee. Notify the Chairman at once. Do not employ attorneys.

MAY, 1919

Editorial

THE ANNUAL MEETING.

The annual meeting to be held in Peoria, May 20, 21 and 22, now promises well. During the winter months there did not seem to be much enthusiasm, but as the time for meeting draws near there seems to be a "moving spirit."

The program is an especially good one, and this, we think, is one reason—and perhaps the chief one—for the increased interest. Many of our members are returning from the service, and perhaps we all feel that it is time for a gathering of "the clans." The fact that Peoria is sufficiently large with ample hotel accommodations to care for the Society conveniently and comfortably, will also be a factor in drawing an attendance.

If the members wish to be of value to the Society, we think there is seldom a time in which their attendance at an annual meeting is of so much importance or of so much value to the profession at large as at this time. This, largely because of the legislative situation. It is possible, of course, that legislative matters will at the time of the meeting be too far advanced to be subject to much influence, but many things may happen during the closing days of a legislature. There have been more vicious medical bills presented to the legislature this session than is usual, but fortunately little has really been done at this date, and it is possible that the Society, while in session, may direct some aid or influence.

The doctors have all had an arduous winter and all need a few days away. Come and help swell the attendance.

RESOLUTION ADOPTED BY ILLINOIS STATE MEDICAL SOCIETY THROUGH ITS COUNCIL APRIL 16, 1919.

WHEREAS, The Civil Administrative Code provides for an Advisory Committee for the Registered Nurses consisting of five persons, each of whom is a registered nurse in the State of Illinois, and

WHEREAS, The medical profession chiefly is concerned in the education, training and employment of nurses; therefore, be it

Resolved, That the medical profession of the State of Illinois, through its council, recommends the enactment into law of Senate Bill No. 123, House Bill No. 175, which bills make provision for an equitable representation on this committee.

The above resolution was passed unanimously by the council and was done in the interest of Senate Bill No. 123, House Bill No. 175. The interest in this bill arises from two factors; first,

that the present nurses' board, composed of graduate nurses only, with the assistance of the Department of Registration and Education, has brought about a condition in the nursing world which is decidedly against public welfare; second, that the nursing board in its policy of administration is trying to make it impossible for any small hospital to exist in this state.

There are many hospitals throughout the state doing excellent work and capable of giving excellent training to nurses. These hospitals have in many instances been built by the doctors and are run by the doctors. Most of them do not pay returns on the financial investment, and the public is about the only beneficiary. The nurses in them are trained by the doctors, and again the public is dependent on these nurses so trained for nursing service.

The nursing board, composed of trained nurses only, has no interest in the training of nurses, save that of reducing the number of trained nurses, thereby being able to maintain the price of nursing service so high that the mass of the people can not afford it. It matters not how many people die annually from lack of nursing service.

Clearly the doctors who furnished the money to build these hospitals and who are training nurses should have some representation on this board. Also a change in the personnel of this board with physicians represented would prevent much of the unnecessary interference with hospitals' management, that is now being practiced by this autocratic, supercilious aggregation labeled as the nursing board that has been tolerated the past few years to the great detriment of public welfare.

Obituary

DR. DUNCAN R. MacMARTIN.

Duncan R. MacMartin, Chicago; McGill University, Montreal, 1888; aged 54; a Fellow A. M. A.; Associate Professor of Surgery, Chicago Polyclinic Hospital; Surgeon St. Luke's and Henrotin Hospitals; house physician at the Great Northern Hotel for twenty years; died suddenly from apoplexy in his bath, April 30.

Dr. MacMartin had a very large acquaintance

and practice among the traveling public as well as among the local townsmen of every grade in society.

As a member of the Medico-Legal Committee of the Illinois State Medical Society for several years and chairman the past year, his services were highly efficient. The Society in his death has lost a loyal exponent of the medical man devoted to the interests of the profession.

THE SECRETARIES' CONFERENCE

I desire to call the attention of the medical profession of Illinois who expect to attend the meeting of the State Medical Society to be held at Peoria, May 20-22, to a part of the program which is of interest to every member of the State Medical Society whether he is now secretary or ever has been secretary of any county medical society.

This part of the program is to be given before "The Secretaries' Conference" and should interest every member of the State Medical Society.

In former years the attendance at these conferences has generally been rather limited, though many of the papers were very interesting to all who heard them, and were given by noted men of ability.

We are fortunate this year in being able to secure men to address this conference whose names are bright stars in county society work. Dr. E. W. Fiegenbaum of Edwardsville, our president, and Dr. C. W. Lillie of East St. Louis, a former president, are at present and have for years been secretaries in their respective counties, and it is largely to their efficient work that their counties are so well known throughout the state. Dr. H. A. Chapin of Jacksonville was for many years the efficient secretary of Greene County. Dr. Don W. Deal of Springfield, who has done such efficient work on the Legislative Committee and so well known to all, will interest all who are fortunate enough to be present to hear his address.

This program is one which should attract a large attendance of physicians, and I hope to see every secretary in the state and all others who are able to present at this conference.

T. D. DOAN,

President Secretaries' Conference.

Illinois State Medical Society
SIXTY-NINTH ANNUAL MEETING,
PEORIA, MAY 20, 21, 22, 1919.

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ORDER OF PROCEEDINGS

Registration office and headquarters in the Exhibit Hall in basement of the Shrine Temple.

First Day—Tuesday Morning

9:00—Eye, Ear, Nose and Throat Clinic, St. Francis Hospital.

First Day—Tuesday Afternoon

1:00—Eye, Ear, Nose and Throat Clinic, St. Francis Hospital.

2:30—Call to order of the Society in General Session, by the President, E. W. Fiegenbaum of Edwardsville, Shrine Temple. Report of the Chairman of Committee on Arrangements, C. U. Collins, Peoria.

3:00—Call to order of Secretaries' Conference by President T. D. Doan, Kankakee, Shrine Temple.

4:00—Meeting of Committee on Credentials for House of Delegates, Congregational Church.

First Day—Tuesday Evening

6:30—Banquet for the Section on Eye, Ear, Nose and Throat, Jefferson Hotel.

8:00—Call to order of "House of Delegates," by President E. W. Fiegenbaum, Congregational Church.

Second Day—Wednesday Morning

9:00—Call to order of the Sections for the reading and discussion of the papers of the program.

Sections on Medicine and Surgery; Shrine Temple.

Section on Eye, Ear, Nose and Throat; Gold Room, Jefferson Hotel.

Section on Public Health and Hygiene; Congregational Church.

12:00—Adjournment for luncheon.

Second Day—Wednesday Afternoon

2:00—Call to order of the Society in General Session by the first vice-president, H. C. Blankmeyer, Springfield, Shrine Temple. President's Address, E. W. Fiegenbaum, Edwardsville.

Oration on Medicine, Isaac A. Abt, Chicago.

Continuation of Scientific Program.

Second Day—Wednesday Evening

Entertainment for Members and Friends. Final arrangements to be announced.

Third Day—Thursday Morning

9:00—Call to order of Sections on Medicine, Surgery and Public Health and Hygiene in joint session for the continuation of program, Shrine Temple.

9:00—Call to order of the House of Delegates for election of officers, Congregational Church.

- 11:00—Oration on Surgery—Retrocecal Appendix—Jabez N. Jackson, Kansas City, Mo.

Third Day—Thursday Afternoon

- 1:30—Reconvening of Sections.
2:30—Call to order in General Session to receive the report of the House of Delegates.
Induction of the President-elect.
5:00—Final adjournment.

ENTERTAINMENT FOR LADIES

Wednesday Afternoon

- 1:30—Automobiles will be at the Jefferson Hotel for a ride over the city.
4:00—Tea at the Country Club.

Wednesday Evening

Entertainment at the Coliseum. Final arrangements to be announced.

OFFICIAL PROGRAM

SECTION ON MEDICINE

- H. W. Cheney, Chairman.....Chicago
Elizabeth B. Ball, Secretary.....Quincy

SECTION ON SURGERY

- H. A. Millard, Chairman.....Minonk
C. W. Poorman, Secretary.....Chicago

Wednesday, May 21, 1919, 9 A. M.

1. The Selection of a Practical Method of Blood Transfusion. Illustrated by Motion Pictures—Karl F. Snyder, Freeport.
Discussion—C. H. Hopkins, Chicago;
W. F. Grinstead, Cairo.
2. The Unwarranted Sacrifice of the Tonsil, with illustrative charts—H. M. Harrison, Quincy.
3. Some Phases of War Surgery—Nelson M. Percy, Chicago.
Discussion—Lieut. Col. Dean Lewis, Ft. Sheridan.
4. Congenital Syphilis—Robert Krost, Chicago
Discussion—Joseph Brennenman, Chicago
5. Syphilis a Factor in Gastro-Intestinal Disturbances—H. M. Mack, Chicago.
6. Surgical Treatment of Gastric Ulcer, with Report of Cases—W. J. Carter, Mattoon.
Discussion—T. A. Bryan, Mattoon;
W. R. Marquardt, Elmhurst
7. Medical Lessons from Our War Experience—C. W. Barrett, Chicago.

8. The Development of the Colon and the Surgical Importance of Non-Rotation of the Colon—F. Buckmaster, Effingham.
Discussion—A. D. Bevan, Chicago.
Adjournment.

GENERAL SESSION.

Wednesday, May 21, 1919, 2 P. M.

9. President's Address—E. W. Fiegenbaum, Edwardsville.
10. Oration on Medicine—Isaac A. Abt, Chicago
11. "Special Anesthesia in General and Genitourinary Surgery"—John S. Nagel, Chicago, and George F. Thompson, Chicago.
Discussion—George W. Green, Chicago;
Wm. Allen Pusey, Chicago.
12. The Habitat and Distribution of Dangerous Streptococci in the Body—D. J. Davis, Chicago.
13. Chronic Pancreas—Hugh MacKechnie, Chicago.
Discussion—C. E. Humiston, Chicago;
Hyde West, Woodstock.
14. Infections of the Gall Bladder and Their Treatment—Franklin P. James, Peoria.
Discussion—J. V. Fowler, Chicago;
H. D. Junkin, Milford.
15. A Resumé of the Year's Work in Radium Therapy—C. W. Hanford, Chicago.
Discussion—Albert W. Meyer, Bloomington.
16. Surgical Treatment of Enuresis in the Adult Female—F. C. Schurmeier, Elgin.
Discussion—H. J. Kretschmer, Chicago.

Thursday, May 22, 1919, 9 A. M.

1. Our Present Knowledge of the Bacteriology and Pathology of Influenza and Its Complications—Joseph F. Biehn, Chicago.
Discussion—Arthur Isaac Kendall, Chicago.
2. The Prophylaxis and Treatment of Influenza and Pneumonia: (a) Prophylaxis—Herman N. Bundesen, Chicago.
Discussion—J. E. Siegel, Collinsville.
(b) Treatment—J. O. Cobb, U. S. Public Health Service.
3. The Aftermath of Influenza and Pneumonia—Frederick Tice, Chicago.
Discussion—C. T. Foster, Rock Island;
George W. Parker, Peoria,
and C. W. East, Springfield

4. Bilateral Pneumothorax—Wilson Ruffin Abbott, Springfield.
Discussion—George Thos. Palmer, Springfield.
5. Some Army Aspects in the Prevention and Treatment of the Pneumonias and Influenza—W. W. Hamburger, Chicago.
Discussion—G. C. Craig, Rock Island.
6. Oration on Surgery—Jabez N. Jackson, Kansas City, Mo.
7. Combination of Radical Surgery and Roentgentherapy in Recurrent Deep-Seated Inoperable Carcinoma—Emil G. Beck, Chicago.
Discussion—J. F. Percy, Galesburg.
8. Encephalitis Lethargica—S. S. Winner, Chicago.
Discussion—Peter Bassoe, Evanston.
9. Cesarean Section—Chas. E. Parker, Sterling.
Discussion—C. E. Paddock, Chicago.
10. The Dakin-Carrell Treatment of Infected Wounds—Wm. Fuller, Chicago.
Discussion—J. W. VanDerslice, Oak Park; J. B. Bacon, Macomb.
11. The Medical Officers' Training Camp—J. M. Hoyt, Nokomis.
Discussion—Mark Goldstein, Chicago.
12. Pelvic Inflammation in Women from the Standpoint of the General Surgeon—H. N. Rafferty, Robinson.
Discussion—Frank P. Norbury, Springfield.
13. The Tuberculous Goiter Patient—E. P. Sloan, Bloomington.
14. Perforating Injuries of the Knee Joint—H. C. Mitchell, Carbondale.
15. Semmelweis and His Fight for Asepsis—C. B. Johnson, Champaign.
16. Gas Poisoning and its Effect on the Respiratory System—Capt. Robert S. Berghoff, Camp Grant, Ill.

SECTION ON PUBLIC HEALTH AND HYGIENE

W. H. Cunningham, Chairman.....Rockford
G. G. Burdick, Secretary.....Chicago

Wednesday, May 21, 1919, 9 A. M.

1. The History of Influenza with Statistics on the Pandemic of 1918-1919—Wade H. Frost, U. S. Public Health Service.
2. The Attempt to Control the Epidemic in the Nation at Large—Allen J. McLaughlin, U. S. Public Health Service.

Discussion—John Dill Robertson, Chicago.

3. The Attempt to Control the Epidemic in Illinois—John J. McShane, Springfield.
Discussion—W. C. Clarke, Cairo.
4. The Local Health Officer and His Problems—E. W. Weiss, Ottawa.
Discussion—A. L. Mann, Elgin.
5. Three Typhoid Fever Outbreaks in an Illinois City—M. J. Sjöblom, Springfield.
6. The Relation of the Physician to Public Promotion—H. N. Heflin, Kewanee.
Discussion—H. M. Orr, LaSalle.
7. Relationship of the State Department of Public Health to the Medical Profession—C. St. Clair Drake, Springfield.
Discussion—J. A. Wheeler, Springfield.
8. Health Insurance From the Standpoint of the Physician—Chas. J. Whalen, Chicago.
9. The Laboratory as an Indispensable Institution in Public Health and General Medical Service—Martin Dupray, Springfield.
Discussion—F. O. Tonney, Chicago.
10. Tuberculous Infection, Its Relation to Public Health—Walter B. Metcalf, Chicago.
11. General Health Activities and Their Effect on Tuberculosis—George Thomas Palmer, Springfield.
Discussion—F. M. Meixner, Peoria.

SECTION ON EYE, EAR, NOSE AND THROAT

Wednesday, May 21, 1919, 9 A. M.

1. Serpiginous Ulcer of the Cornea and Treatment—Willis O. Nance, Chicago.
Discussion—Geo. W. Mahoney, Chicago.
2. Mastoiditis, Its Diagnosis and Treatment—Richard J. Tivnen, Chicago.
Discussion—Thomas O. Edgar, Dixon.
3. Various Phases of Myopia—Heman H. Brown, Chicago.
Discussion—Michael Goldenburg, Chicago.
4. The Illinois State Institution for the Blind—A. L. Adams, Jacksonville.
Discussion—Walter L. Frank, Jacksonville.
5. Glaucoma—H. W. Woodruff, Joliet.
Discussion—Edward F. Garraghan, Chicago.

6. Binocular Cataract Operations—John R. Hoffman, Chicago.
Discussion—Dwight C. Orcutt, Glencoe.
7. Hyperesthetic Ethmoiditis—Harry L. Pollock, Chicago.
Discussion—Otto J. Stein, Chicago.
8. Immediate Closure in Selected Cases of Acute Mastoiditis. Report of a Case—J. Sheldon Clark, Freeport.
Discussion—John F. H. Deal, Springfield.
9. Is Malaria an Etiologic Factor in Iritis?—R. C. Matheny, Galesburg.
Discussion—James W. Dunn, Cairo.
10. What Results May We Expect Following Tonsillectomy and Adenectomy—C. F. Burkhardt, Effingham.
Discussion—C. B. Voigt, Mattoon.
11. Modern Surgical Technique in Tonsillectomy—J. Z. Bergeron, Chicago.
Discussion—Henry R. B. Boettcher, Chicago.
12. Iritis—Alfred N. Murray, Chicago.
Discussion—Francis Lane, Chicago.
13. Cocaine Anesthesia in Nasal Operations—A. H. Andrews, Chicago.
Discussion—Arthur M. Corwin, Chicago.
14. Submucous Operations—Oliver Tydings, Chicago.
Discussion—B. F. Andrews, Evanston.
15. Early Extraction of Traumatic Cataracts—Thomas Faith, Chicago.
Discussion—Charles H. Francis, Chicago.
16. Eye Involvements Following Focal Infections—E. R. Crossley, Chicago.
Discussion—Frederick D. Vreeland, Evanston.
17. Sphenoid Sinus Diseases. Exhibition of Sections—John A. Cavanaugh, Chicago.
Discussion—Charles B. Younger, Chicago.
18. Radium in Eye, Ear, Nose and Throat Diseases—Edward E. Edmondson, Mount Vernon.
Discussion—Otto T. Freer, Chicago.
19. Optic Neuritis, the Etiologic Relation of Diseased Tonsils. Report of a Case—Carroll B. Welton, Peoria.
Discussion—David Salinger, Chicago.
20. Influenza—Charles H. Long, Chicago.
Discussion—J. Whitefield Smith, Bloomington.
21. Oto-Laryngologists in General Surgery, as an Emergency, "Over There"—Joseph C. Beck, Chicago. Discussion—George W. Boot, Evanston.

SECRETARIES' CONFERENCE

- T. D. Doan, President.....Kankakee
L. O. Frech, Secretary.....Whitehall
1. Reasons Why Some Physicians Do Not Attend Medical Societies—H. A. Chapin, Morgan County.
 2. Alive or Dead—E. W. Fiegenbaum, Madison County.
 3. The Secretary's Relation to the Legislative Committee—Don W. Deal, Sangamon County.
 4. A Plea for Greater Efficiency in County Society Officer—C. W. Lillie, St. Clair County, Councillor, 9th District.

EXHIBITORS

Horlick's Malted Milk Company.
Chas. H. Phillips Chemical Company.
W. B. Saunders Company.
Mellins Food Company.
C. V. Mosby Company.
H. G. Fischer & Co.
Childs Drug Company.
Radium Chemical Company.
Abbott Laboratories.
Medical Protective Company.
Hanovia Chemical & Mfg. Co.
John McIntosh Company.
Lederle Antitoxin Laboratory.
E. R. Squibb & Sons.

PROGRAM

HEALTH SUNDAY

Peoria, Illinois, May 18, 1919

MASS MEETING AT THE COLISEUM, 3 P. M.

SADIE BAY ADAIR, M. D., CHAIRMAN

MUSIC

PRAYER—Rev. J. C. Hazen, President of the Ministerial Association of Peoria.

ADDRESS—Social Evils in Their Various Phases.

Dr. L. P. H. Bahrenburg, of the Public Health Service Department, Washington, D. C.

Other Speakers—

Dr. E. W. Fiegenbaum, Edwardsville, Ill.; President Illinois State Medical Society.
 Capt. James Warren Van Derslice, M. D., Oak Park, Ill.; President-Elect Illinois State Medical Society.
 Dr. John Dill Robertson, Commissioner of Health, City of Chicago.
 Dr. Clifford U. Collins, Chairman, Committee on Arrangements, Illinois State Medical Society.

Evening Program

First Methodist Church at 7:30 P. M.

"Stewardship of Health"—Dr. E. W. Fiegenbaum, President Illinois State Medical Society. Dr. E. P. Sloan, Bloomington, Chairman.

Central Christian Church at 7:30 P. M.

"Medicine in the Army" (Maintaining Morale)—Capt. James Warren Van Derslice, President-Elect Illinois State Medical Society. Dr. Clifford U. Collins, Chairman.

First Baptist Church at 7:30 P. M.

"Health Fundamentals"—Dr. John Dill Robertson, Commissioner of Health, Chicago. Dr. Grace H. Campbell, Chairman; Secretary Medical Women's Society of Chicago.

ANNOUNCEMENT OF THE MEETING OF
THE EYE, EAR, NOSE AND THROAT
SECTION.

PEORIA, ILLINOIS, MAY 20, 21, 1919.

This will be a gathering of regular fellows—regular "Go-getters"—who *do* things and present their broad findings for the relief and benefit of their fellow men. They will offer at this time in meeting assembled:

FOOD for Thought in the *Clinic*,

FOOD for the Innerman in a *Banquet* and

FOOD for Progress in the *Program*.

All of these are yours to enjoy and pleasantly

remember for months to come if you join the ranks of enthusiastic "Eyes - Ears - Nose - and - Throats" attending Peoria, this state, on this May 20 and 21.

CLINIC.

New and exceptional cases of unusual interest to our members will hold the attention during the *morning session*, commencing sharply at NINE O'CLOCK, *Tuesday, May 20*. This *Clinic* will be held at St. Francis Hospital. The demonstrations and operations during the *forenoon* will be limited to the *Ear, Nose and Throat* cases. The *afternoon* will be given over exclusively to operations and demonstrations of *Eye* cases. The subject matter is so "chockfull" of remarkable interest to every member that the *time* bids fair to be all too short to fully enjoy all the splendid features prepared for this *epoch-making* occasion. *YOU* are urged to contribute largely of your *presence* and *enthusiasm*.

Dr. Charles D. Thomas, Central National Bank Building, Peoria, Ill., is Chairman of Arrangements and will be pleased to hear from members of the state society who desire to present cases for demonstration. You are cordially invited to communicate with Dr. Thomas and acquaint him with your wishes.

The new spirit of the times will abound at this Clinic, which will be conducted by able men, men recognized as foremost in their specialties and in our chosen calling—and something of great value will be missed by those who fail to attend. Make no mistake. "Tab" this date and place in your memory—you will hear about this later on and—and don't fail to "get your name in the pot" for the feast of good things to *eat* at our Annual

BANQUET.

The spread will be laid at the Cr ve Coeur Club on Tuesday evening, May 20. "Take a Tip From Father." Whatever you do *don't miss* this Big Feed, and *remember*, the festivities begin promptly at Six-Thirty (6:30). There will be some remarkable excursions, and every member is expected to operate freely (discussions allowed while operating). Securing early reservations will assist those in charge of arrangements. Kindly send checks for number of tickets desired (\$3.00 per plate) to Dr. Charles D. Thomas, facilitating general plans.

Digestive assistants in general doses of enter-

tainment will be provided, and plenty of good music, wit and oratory will abound, together with good-fellowship of Auld Lang Syne. It is a splendid privilege to renew our comradeship at affairs like this, and the present opportunity will be an exceptionally enjoyable one.

Make it a point to get a bit more out o' life at this reñnion of old colleagues at Peoria on the 20th and 21st of May!

PROGRAM.

In the Gold Room of the Hotel Jefferson at 9 o'clock (NINE O'CLOCK) on the morning of May 21st the "E., E., N. & T." Section will present a Scientific Program that for material, authorships and interesting features has rarely, if ever, been excelled in a similar session.

The papers will be "snappy," progressive and deal directly with important phases of our specialties. Limited to ten minutes each and three minutes for opening discussions, there will be no dull moments, and we are assured of a genuine "Feast of reason and flow of soul."

TWELVE O'CLOCK NOON will bring an intermission for the luncheon hour.

Reassembling promptly at ONE-THIRTY, the program will be resumed and will furnish enjoyment up to FOUR-FIFTY-NINE, Peoria time.

With a survey of all the splendid reasons for a record-breaking attendance, to influence decision and determination to be present at this "gathering of the clan," place a circle around (20) and (21) on your desk calendar for May, then sit right down and write for those reservations *at once*—today—to Dr. Charles D. Thomas, Central National Bank Building, Peoria, Ill.

It will indeed be one of the most pleasant memories of your professional career that you attended the "Annual" at Peoria, Illinois, in May, 1919.

"LET'S GO!"

Yours fraternally,

WESLEY HAMILTON PECK, Chairman.

Columbus Memorial Bldg., 31 N. State St.,

Chicago.

FRANK ALLPORT, Secretary,

Chicago Savings Bank Bldg., 7 W. Madison St.,

Chicago.

OBNOXIOUS MEDICAL LEGISLATION.

In the April number editorial attention was called to certain bills before the Illinois State

Legislature so impudently designed to give the chiropractors and osteopaths practically the right to practice medicine. The effrontery that could ask the legislators to give such powers to such ignorant rogues is amazing and discouraging, as it can not be denied that it is quite possible that these vicious bills will pass. Were the medical profession in the authoritative and respected position it is entitled to hold, it would be hopeless to even get the bills considered. Far from holding such a place of honor in the community, however, the doctors of the state are the object of a contemptuous disregard, well voiced in the eloquent addresses of Professor Shepardson to our medical societies, which were meekly listened to without resentment—an humble attitude characteristic of the profession which hears so much abuse that it is really beginning to think itself a sort of culprit.

There are many reasons for this deprecating spirit on the part of the doctor. He hears the cults and fakes lauded by the press; he sees millions given to Christian Science, while his own schools go begging. When he wishes to refresh or add to his knowledge the state gives him no opportunity. If he has a life-and-death operation to do there is not, what there should be to give assurance to his skill, a cadaver offered him by the state to perform it upon. In short, to quote from a popular song, the community, by its hostility to medical education and its lack of support of medical schools, "makes the doctor what he is today," but it is not "satisfied" and blames the honest fellow, eager to improve himself, for its own shortcomings in helping him to make himself more efficient. All of this makes the doctor dissatisfied with himself, gives him a sense of inefficiency and self-distrust which is reflected in his low charges and lack of aggressiveness toward his critics. If he fights his own battles in the legislature against the impudent rascals who grasp at his rights, it is always with the hopeless feeling that he will be misunderstood, thought attempting to establish a monopoly and that there is no use in arguing his case. What the doctor needs above all things is an influential political friend who is not a doctor. Such a friend could be Professor Shepardson. Ex-officio, his authoritative voice could be used to educate the public in regard to the needs of the profession. He could point out that it is a degradation of the high office of the De-

partment of Education and Registration and an indication of the low intellectual level of the State of Illinois to license such cheats as osteopaths and chiropractors, not to speak of enlarging their powers. It would take courage to do this, but his opinion would have immense weight. He could also advocate a system of state medical education, in which respect Michigan gives us so brilliant and honorable an example in its medical department of the University of Michigan, whose graduates enjoy a respect in their state which is eloquent of the pride felt by the people of Michigan in their university. He could also go further and advocate a statewide system of graduate medical schools with abundant anatomical material to help the doctor keep his knowledge bright for the good of the people of the state. In short, were he the "friend of the medical profession" that he professes to be, he could do a world of good to the state. Such activities would be far better than trying to annually fine all of the doctors in the state while smiling upon the cults and browbeating the doctor. He can not believe in the greatness of the noble science of medicine and not do all in his power to uplift our profession.

OTTO T. FREER.

THE PRESENT STATUS OF THE NURSING BILL.

On April 16 the Senate Committee passed out a bill on nursing but did not report it to the Senate until April 22. The bill as reported out is neither the original nurses' bill nor the people's bill introduced by the profession. The present bill is known as the Hull Bill No. 116. One hundred and sixteen is the number of the original nurses' bill. This was amended by the committee by striking out everything after the enacting clause and substituting the present bill. It is claimed that this is a compromise bill, an agreed bill, and that it contains those features which the profession asked for in their bill. This is in no sense the case.

The medical men who are representing the profession in this matter did not know the contents of Hull Bill No. 116 and were unable to learn anything about the bill until after it had been introduced into the Senate.

The bill as presented is absolutely impossible in that it provides for two distinct kinds of

training schools with two distinct classes of pupils; one school turning out nurses and the other turning out nursing attendants. The whole scheme is so absurd that it seems as though the idea must have been to make it so impossible that it would necessarily fail in accomplishing what is so badly needed. The term "attendant" is also objectionable, as it has been applied to those who care for the insane for so long that it has come to have that meaning attached to it. The bill fails to provide for a shorter training for a nurse for the sick such as is so much needed by the people.

To make the bill of any value whatever it will be necessary to amend it on the floor of the Senate, and this should certainly be done. The physicians throughout the state should see to it that their respective senators should be correctly informed that this is not an agreed bill and that it will be necessary to amend the bill in order to put it into workable shape.

M. L. HARRIS

JO DAVIESS COUNTY BULLETIN

We are in receipt of the first number of the *Bulletin* of the Jo Daviess County Medical Society issued in April by Dr. G. W. Rice, secretary. The salutatory and article on "Gullibility" are published under society proceedings, and a letter from Dr. Rice appears in correspondence.

The *Bulletin*, with its motto, "Pep," promises to be a welcome visitor. While greatly interested in current events, the new *Bulletin* begins a series of biographies of medical pioneers of the county which are of permanent historical value. Every one interested in the early history of medicine in the state should read the articles on Drs. Horatio Newhall and Edward D. Kittoe.

A RESOLUTION ADOPTED BY THE OHIO FRATERNAL CONGRESS, FEBRUARY 3, 1919, AT COLUMBUS, OHIO.

WHEREAS, Four of the seven members of the Ohio Health and Old Age Insurance Commission have recommended the adoption in this state of a system of compulsory state health insurance, and

WHEREAS, This system of so-called insurance has been a failure in Germany, where it originated, and in other European countries, having

failed to reduce the number of cases of sickness or the duration thereof and having produced an enormous amount of fraud and malingering, and

WHEREAS, Its adoption in this country would cause the ruin of our splendid structure of fraternalism, place a needless burden on both capital and labor and seriously interfere with the general welfare of the community and the sacred rights and liberties of the individual, and

WHEREAS, The National Fraternal Congress, at its annual meeting held in Philadelphia in 1918, went on record in opposition to any such form of governmental activity; therefore, be it

Resolved, That the Ohio Fraternal Congress does hereby strongly disapprove of the adoption in Ohio or elsewhere in this country of compulsory state or governmental health insurance; and be it further

Resolved, That this Congress approves of plans for sickness prevention by extending and broadening the powers of the authorities charged with the duty of administering laws dealing with health and sanitation, and by a more strict enforcement of said laws and enlarged powers for the conservation of health.

HEALTH INSURANCE BEATEN IN NEW YORK

For the third time Health Insurance has been turned down in New York. In the General Assembly just closed the Health Insurance Bill passed in the Senate, but was defeated in the House. The doctors of New York are to be congratulated on their great success in defeating this attempted vicious legislation.

Health Insurance Committee

GEORGE APFELBACH
ED. H. OCHSNER
J. R. BALLINGER
CHAS. K. WHALEN

THANKS OUR HEALTH INSURANCE COMMITTEE

THE MEDICAL SOCIETY OF THE COUNTY OF
NEW YORK

New York, April 26, 1919.

Health Insurance Committee of

Chicago Medical and State Medical Societies,
Chicago, Ill.

GENTLEMEN:—Thank you for the copy of the "Arguments Against Compulsory Health Insurance." I have found valuable help in many

conferences I attended this winter on health insurance.

Our state bill failed in the Assembly after it passed the Senate. We secured many amendments but they refused to add our demand for a state-wide incorporated panel and collective bargaining by the panel.

I should like your criticism of the enclosed bill which passed the Senate.

Yours very truly,

E. ELIOT HARRIS.

33 West 93rd street.

FIFTY-FIRST GENERAL ASSEMBLY OF ILLINOIS.

PLEA FOR HOUSE BILL 353, BEFORE THE COMMITTEE ON EFFICIENCY AND ECONOMY,
SPRINGFIELD, ILLINOIS, APRIL 22, 1919.

A PLEA FOR THE EXPENDITURE OF ONE CENT FOR RESEARCH INTO CAUSE, CURE AND PREVENTION;
FOR EVERY DOLLAR EXPENDED UNDER THE DEPARTMENT OF PUBLIC WELFARE IN CUSTODY, CONFINEMENT AND PALLIATION.

BAYARD HOLMES, M. D.

Secretary of the Society for the Promotion of the Study of Dementia Præcox.

CHICAGO.

To Otto C. Sonnemann, Carlinville, Ill., Chairman; James A. Watson, Elizabethtown, Ill.; James M. Pace, Macomb, Ill.; Fred A. Brewer, Tampico, Ill.; Charles W. Baker, Monroe Center, Ill.; A. L. Lindstrom, Galesburg, Ill.; Charles W. La Porte, Peoria, Ill.; James A. Steven, 2148 North Clark street, Chicago, Ill.; William Noble, Gibson City, Ill.; Robert Irwin, Mount Carroll, Ill.; J. L. Hammond, Anna, Ill.; Frank Ryan, 2139 West 13th street, Chicago, Ill.; Ben L. Smith, Pekin, Ill.; Archie M. Vance, Paris, Ill.; Benjamin M. Mitchell, 3210 West Washington boulevard, Chicago, Ill.; Committee on Efficiency and Economy.

OBJECT:—This bill seeks to secure the establishment of a laboratory of research unhampered by service, education or diversion of interest of any kind, to be supported by a fund fluctuating with the future needs of such research and to be conducted by a faculty selected and appointed in the same manner as professors in the University of Illinois are now appointed. The subjects of

research into cause, cure and prevention are to be undertaken in the order and the proportion or intensity in which they numerically appear among the wards of the Department of Public Welfare.

Mr. Chairman and Gentlemen of Committee on Efficiency and Economy:

In the years 1882-1886 it was my great privilege to serve the Cook County Hospital first as a chemist and later as an interne. At that time there were annually 38,000 deaths in the United States from a disease known as "typhoid fever." The County Hospital at that time had three wards for these patients. Each ward had 63 beds. One of the male wards, which was full of these patients from July to April, it was my duty to care for from July to January. I studied there my first one hundred cases of typhoid fever. Twelve died within the first twenty-four hours after admission to the hospital. Seventeen per cent. of the remainder died in the hospital and eighty-three per cent. were discharged or sent to the poor house at Dunning, after an average stay at the County Hospital of seventy days.

During this period the micro-organism was discovered which was later acknowledged (1885) to be the cause of the disease.

The death rate in the civilized countries of the world was about 300 annually to 1,000,000 living, and in cities somewhat higher (1,400 in Paris and 600 in London). This death rate fell gradually with improved water supply, food supply and social betterments resulting from the discovery of the cause of the disease, until it was less than 50 to the 1,000,000 living inhabitants.

In armies, however, and especially in our own army in Cuba in 1898, and in the British army in South Africa, typhoid was the cause of more deaths than gun shot wounds and all other diseases combined. In the Russo-Japanese war, with 500,000 expeditionary forces, morbidity was 1.5 per cent. of all casualties from disease and gun shot wounds together.

But research had been going on in the laboratories of the world and the principles of immunity and artificial protection had been established and the protective injections for typhoid fever had been perfected. This was an individual discovery like the inoculation and the vaccination against

small pox. It was, however, the result of direct, systematic, scientific research by one medical scout. The course of the conquest of typhoid fever has been typical of individual medical research and accidental discovery may be expressed in the following series of discoveries:

1. The patients were observed and the symptoms noted. All those conforming to a certain course were given a place under a certain name, expressive of some particular feature—in this case under "fever." Some modifying word was then added, according to the experience of the time or place, e. g., nervous fever or typhoid, typhus-like fever (1830).

2. At autopsy the intestines were found ulcerated in a typical manner, Peyer's patches and coincident lesions noticed (1845).

3. The cause of the disease was discovered and its life history worked out. (Grafka, 1885.)

4. A method of objectively diagnosing the disease from a drop of the patient's blood. (Widal, 1896.)

5. A method of producing artificial immunity in those about to be exposed. (Wright, 1900.)

6. A method of terminating the infection by antitoxic serum (?)

Typhoid is in the last category of the series. Protection from the disease is complete. It has become a slogan of sanitarians and physicians that "When a citizen succumbs to typhoid fever some one should be hung."

There are, however, at least eight distinct steps which have been taken by research in the conquest of diseases of various kinds, namely:

1. The symptomatology, clinical history, course, complications and terminations. The method of Louis and Sydenham.

2. The autopsical findings, gross and microscopic, pathologic anatomy.

3. The specific *vis morbi*, the biology or parasitology.

4. The course of initiation of the disease by the *vis morbi* and the resulting rational methods of prevention.

5. The test for presence of disease—serology.

6. The production of artificial immunity—immunology.

7. The test showing presence of immunity either natural or artificial.

8. Medicinal cure—pharmacology and toxicology.

Eight steps taken in the conquest of disease.

	1. Symptoms and name.	2. Autopsy and pathology.	3. Specific cause.	4. Course of the initiation.	5. Diagnostic test.	6. Production of artificial immunity.	7. Test for the natural or artificial immunity.	8. Medicinal cure.
Small pox.	+	+	0	+	0	+	0	0
Syphilis ...	+	+	+	+	+	0	0	++
Diphtheria	+	+	+	+	0	+	+	00
Malaria ...	+	+	+	+	0	0	+	+
Cholera								
Infant. ..	+	+	0	+	0	0	0	0
Wound								
Diseases.	+	+	+	+	0	0	0	0
Tetanus ..	+	+	+	+	0	+	0	0
Spinal Men-								
ingitis ..	+	+	+	0	+	+	0	0
Sleeping								
Sickness.	+	+	+	+	0	0	0	+
Tubercu-								
losis	+	+	+	+	+	0	0	0
Pneumonia.	+	+	+	0	0	0	0	0
Rheuma-								
tism	+	+	+	+	0	0	0	0
Plague	+	+	+	++	0	0	0	0
Yellow								
Fever ...	+	+	0	+	0	0	0	0
General								
Paresis .	+	+	+	+	+	0	0	+0+0
Dementia								
Praecox .	+	0+	0	0	0	0	0	0
Manic. De-								
pressive .	+	0	0	0	0	0	0	0
Epilepsy ..	+	0+	0	0	0	0	0	0

Every successful research in the conquest of any disease has been a distinct economic saving. It has not only saved lives, but diminished morbidity, and thus diminished inefficiency and vagabondism, but it has laid the foundation of other researches which have assisted in the conquest of other diseases. The discovery of vaccination saved the fourteenth of the human race that formerly died of smallpox alone; it saved the terrible facial deformities and the enormous number of kidney stones and kidney abscesses which occur as the result of smallpox and made stone in the urinary bladder relatively rare. If smallpox had not been conquered by vaccination the industrial revolution which followed steam power could not have been realized. Concentration of population could not have been possible.

The discovery of the causes of wound diseases by Pasteur in 1860 and the methods practiced by Lister in 1866 in Glasgow, might have been used, but for the obstinacy and gross ignorance of the French and German surgeons during the war of 1870-71. This discovery accelerated the

recovery of wounds thirty fold, while at the same time it diminished the death rate from open wounds and from all operations a hundred fold. Every surgical bed, after Lister's demonstration, accommodated thirty times as many patients with open wounds during any year as the same bed served in the pre-antiseptic days in the same period. In the pre-antiseptic period the general hospital had a more grewsome and terrifying reputation than the mad houses, lunatic asylums and state hospitals have today, and for the same reason—their non-remediable function. It was possible to locate one of these hospitals by the fetor and stench which arose from the fermenting wounds. Every dollar invested in hospitals for the treatment of open wounds was made thirty fold more efficient by the methods of Pasteur and Lister. Modern surgery and safe obstetrics were made safe by this method and thus enormously extended.

It is obvious from the history of typhoid that accidental discovery and individual research is a time-consuming method of solving the problems of disease. It is extravagant in life, health and money. Typhoid fever was a widely disseminated disease. Every doctor had patients with typhoid. Indeed, not less than one-fifth of all the practice of the average medical man was on typhoid fever. Between 1882 and 1902 not less than 760,000 persons died of typhoid in the United States, and more than 3,000,000 were sick for ten weeks or more, and ever after were less efficient citizens than they would have been.

During the century after it was recognized as a distinct clinical entity, and during which it was left to accidental discovery and individual research to find out its cause, its method of recognition and the production of an artificial immunity, the loss of life in the civilized world and the monetary loss from this disease can be compared to nothing except the world war just over.

It is the height of folly and false political economy to leave to accidental discovery and individual or private research the solutions of the problems of disease.

The massive scientific attack upon a particular disease has never failed to be rapidly effective. Setting aside the sleeping sickness, kala azar, beri beri, cholera and plague, which are less familiar to our people, let us take the history of yellow fever for example:

Yellow fever has been the greatest curse of tropical and subtropical commerce on the Atlantic for two centuries. It was endemic and always raging in the West Indies. Many books were written about it and many wordy contentions indulged by physicians, legislators, sanitarians and even linguists. Individual experiments were made which seemed to show that it was not contagious. Unprotected whites could wear the garments taken from the bodies of those just dead of yellow fever, or even some anticontagionists allowed blood from the hearts of the dead to be injected under their skin without arousing the disease. Nevertheless other investigators would mass statistics to prove that "a southwest wind" caused the disease to spread, while "a northeast wind" caused it to disappear, or *vice versa*.

All were agreed on quarantine as the only protection, and the United States and the several Atlantic states spent millions in quarantine, and the citizens spent other millions in fleeing north as soon as the quarantine began to leak. Every border state had its own quarantine commission and the whole job was under the Marine Hospital Service.

At last the United States Army had a little tilt with the Spaniards in Cuba and a much more disastrous affair with typhoid fever in the mobilizing camps in the States. The Army also considered the possibility of meeting yellow fever with an army in pacifying the Spanish colonies, a disease which had never before received much attention. For the first time in history the strategy of the army was used against disease. A massive attack was instituted under Walter Reed, which conquered the disease in a few months, made the American Army safe in the West Indies, opened the tropics to civilization and reduced the Panama Canal problem to an engineering feat.

Typhoid required a hundred years of accidental discovery and individual research before it was conquered, while yellow fever capitulated before a massive scientific attack in a few months.

One-third the total State Budget of Illinois is expended on the hopeless custody of the insane. The causes, cure and methods of the prevention of the several insanities, excepting syphilitic and alcoholic, are unknown and unsought. One of these diseases, dementia præcox, fills sixty per cent. of the beds in the State Hospital. It is

believed by many who have studied the results of massive scientific research that this disease could be conquered in a few years if attacked by this method.

In asking for a favorable consideration of this bill my modesty compels me to say that without any formal deputizing, I represent the interests of the following groups:

The resident, committed insane in Illinois	18,000
The sane, but humiliated and abashed individuals in the 18,000 families of the so committed insane.....	90,000
The 8,000 citizens of Illinois who will be drafted by unknown diseases and placed legally in the state hospitals before the next legislature meets.....	8,000
The sane individuals who will be left in the families from which these 8,000 unsuspecting recruits to custody will be drafted	40,000

Total not less than.....156,000

It seems to me no well-informed citizen will oppose the purposes of this bill. It is for the wisdom of this representative body to further the undisputed purposes of this bill by the most expeditious and effective methods. In behalf of the 138,000 sane and uncommitted citizens for whom it is by no presumption that I claim representation, let me thank you for your patient attention and apparent interest.

Frederick Pringle was then called and in a most feeling and analytical manner presented a plea for this bill from the standpoint of the families of the insane yet uncommitted.

The Committee then forwarded the bill to the House with the recommendation that it be passed.

Public Health

HEALTH PROMOTION WEEK

By joint resolution of the General Assembly, the week beginning Sunday, May 11, will be known as Health Promotion Week, and will be observed throughout Illinois by all the governmental and extra-governmental organizations having to do with the public health. The general observance of Health Promotion Week is being carried out by the State Department of Public Health and under the general supervision of W. D. Thurber, whose services are loaned to the State Department of Health by the Illinois Tuberculosis Association for that purpose. A large committee made up of the executive officers of health organizations is devoting itself to the project and of

this committee, Governor Frank O. Lowden is honorary chairman and Dr. C. St. Clair Drake is chairman. The co-operating committee is made up of the following persons: Dr. George Thomas Palmer, president of the Illinois Tuberculosis Association; Francis G. Blair, superintendent of Public Instruction; Dr. E. W. Fiegenbaum, president of the Illinois State Medical Society; Barney Cohen, director State Department of Labor; Miss Jessie Spafford, president Illinois State Federation of Women's Clubs; Dr. John A. Robison, president Illinois Public Health and Welfare Association; Charles Adkins, director State Department of Agriculture; Mrs. Harry Fleming, president Illinois Congress of Mothers and Parent-Teacher Association; Charles H. Thorne, director State Department of Public Welfare; Francis W. Shepardson, director State Department of Registration and Education; John Glenn, secretary Illinois Manufacturers' Association; Duncan McDonald, president Illinois State Federation of Labor; Miss Dorothy Blatchford, secretary Illinois Society for Prevention of Blindness; S. P. Preston, president Illinois Press Association; Mrs. Joseph T. Bowen, state chairman Women's Committee, Council of National Defense; Joseph C. Thompson, director Department of Mines and Minerals; Mrs. Ira Couch Wood, director Elizabeth McCormick Memorial Fund; Miss Helena McMillan, president Illinois State Nursing Association; W. F. Calhoun, commander Illinois Branch Grand Army of the Republic; Elmar M. Lawson, department commander Spanish War Veterans; J. W. Dappert, president Illinois Society of Engineers; H. L. Williamson, secretary Illinois Press Association.

May 11 will be observed generally as Health Promotion Sunday and on that day there will be talks on public health subjects in the churches throughout the state. Monday will be known as Community Clean-up Day; Tuesday will be devoted to the suppression of the fly nuisance; Wednesday will be observed as Better Babies Day and on Thursday all citizens of Illinois are urged to submit themselves to thorough physical examination for the detection of incipient disease. Friday, May 16 will be observed with health activities in all public and private schools and the week will end with pageants and parades on Saturday, May 17.

There has never been a time when public health has so thoroughly occupied the attention of the people as at the present time, and the efforts on the part of the State Department of Public Health to centralize interest in a great educational movement and to coordinate all the various health activities is meeting with enthusiastic response.

The April number of *Health News*, the monthly bulletin of the State Department of Public Health, is devoted to the plans and programs of the Health Promotion Week, and copies of this bulletin will

be sent to all interested persons on application to the offices of the Department at Springfield.

DIVISION OF SOCIAL HYGIENE

During the month of April the Division of Social Hygiene of the State Department of Public Health conducted public meetings for men and women in seventeen cities in Illinois, reaching a total number of over 12,000 persons. Motion pictures, "Fit to Fight," for men, and "The End of the Road," for women, were shown in all communities, and over 34,000 pamphlets on Sex Hygiene were distributed.

The establishment of clinics for venereal diseases is progressing more slowly in Illinois than in other states on account of the fact that the department insists upon thorough cooperation of the local medical profession in the establishment of all such institutions.

Preparations are now being made for the distribution to all physicians in the state of a manual on the treatment of venereal diseases. This manual is issued by the American Medical Association and will be placed in the hands of Illinois physicians during the present month.

LETHARGICA ENCEPHALITIS

Up to the present time there have been ninety cases of lethargica encephalitis reported to the State Department of Public Health from various sections in Illinois. Sixty-two of these cases are in Cook county, and the remainder distributed throughout the state at large. Cases have been reported from Adams, Alexander, Brown, Clark, Clinton, DeKalb, Edgar, Effingham, Ford, Iroquois, Lake, LaSalle, Logan, Macoupin, Madison, McDonough, Menard, Perry, Richland, Rock Island, Sangamon and Vermilion counties.

SMALLPOX

On account of the considerable number of cases of smallpox of a very mild type, the State Department of Public Health is urging all physicians to notify the local Health Department of all cases of suspicious illness and especially of cases of supposed chicken-pox, particularly among adults.

Smallpox is now more or less prevalent in DuPage, Champaign, Lee and Washington counties, and cases continue to be reported from the vicinity of Pekin in Tazewell county.

VISIT OF A FRENCH PHYSICIAN

Dr. Paul E. Davy of Paris, connected with the American Tuberculosis Commission in France, recently visited Illinois to study the methods employed by the State Department of Public Health for the control of tuberculosis and child welfare

work. Dr. Davy made a special study of the organization of the State Department of Public Health under the provisions of the Civil Administrative Code.

Correspondence

VICIOUS LEGISLATION

Galena, Ill., April 17, 1919.

To the Editor:

I have before me a circular from the chairman of our Committee on Medical Legislation outlining the vicious legislation introduced relative to those who are trying to break into the practice of medicine through the back door.

These bills are positive proof that the physicians of the state should wake up and take an active interest in politics. The medical profession should, at the next election, have a candidate for the legislature in every district in this state.

It is time we were demanding a higher class of men as candidates for these offices, and this matter should be taken up by the State Society and every county society in the state, and provisions made to put up a physician candidate in every district at the next election.

I think the JOURNAL should advocate this in every issue, keeping it constantly before the profession.

Yours truly,
G. W. RICE.

BULLETIN No. 3

To the Editor:

Apropos the action of the council of the Chicago Medical Society the other night concerning the director of the Department of Registration and Education in ignoring the medical profession so much as possible, I wish to call attention to the enclosed leaf taken from their *Bulletin No. 3*, in which you will see that the names of the Medical Examining Committee are not published. No official recognition of this committee is found in any of the published literature of the department.

STATE OF ILLINOIS

DEPARTMENT OF

REGISTRATION AND EDUCATION.

Director Francis W. Shepardson
Assistant Director..... E. A. Wreidt
Superintendent of Registration..... F. C. Dodds

Assistant in Professional Education.....
..... W. Barclay Rose

An Examining Committee for Medical Practitioners is appointed from time to time by the director of registration and education, under the provisions of the Civil Administrative Code.

[Printed by authority of the State of Illinois.]

U. S. ARMY BASE HOSPITAL NO. 81.

LT. COL. P. J. H. FARRELL, COMMANDING,
A. P. O. 731, FRANCE.

March 30, 1919.

To the Editor:

Captain W. H. Gilmore, secretary of our society, is attending surgeon at headquarters of the advance section, and since I "discovered him" a few weeks ago we have enjoyed talking of Illinois, the folks and home. I enclose a couple of kodaks of my hospital. Perhaps you will be interested in my trip to Germany.

I think that I sent you a "travelogue" of post cards, showing you that my field of activity extended from G. H. Q. to Alsace-Lorraine, Luxembourg, and to our bridgehead and most advanced post north of Coblenz and the Rhine, Germany, and return through beautiful Paris, the center of world-wide diplomacy, and where our own proud but generous nation is working with might and main with our gallant Allies, dealing out justice and mercy to the enemy that our combined military forces humbled to the dust, after they had for many years felt that the entire civilized world was within their iron grasp and going to be their menials.

I have been in every city and town of any importance, from the French border to the Allied line north of the Rhine, and let me tell you that our enemy is beaten and whipped to a standstill. He fought his best fight, exhausted every known method of warfare, legal and illegal, human and inhuman, and his military life has been crushed out. The science of war, the triumphs of the laboratory, poison gas and the submarine were, after all, no match for the courage, brain, brawn and the muscle of our own American doughboy, Tommie Atkins, Poilu and Anzac. If any American thinks there is any fight left in the enemy let him annoint his fears, for there is not, unless I am a false prophet and a poor judge of fighting material, whose time and training upon each and

every one of the six continents of this world has been wasted.

For the first time in this war I caught up with my oldest son, Great (Captain W. G. Farrell), who is commanding a company of Marines and holding an advanced point north of the Rhine. Several times prior to the armistice we have been in the same sector, but too busy for a family reunion. We enjoyed talking of our "narrow escapes" of meeting each other: for instance, we discovered that I drove right past him in an automobile one night while he and his company were hiking along tired and weary, finishing up a grueling forced march of 31 miles in heavy marching order in one day. He is very enthusiastic and intensely proud of his company and corps. I also found that he is quite proud of two beautiful German dogs that he informs me have become so thoroughly Americanized that they growl and issue a challenge to fight if spoken to in German. Our missionary work is certainly far-reaching.

The good work of our Air Service was in evidence when I drove into Metz, which we had bombed many times. The enemy had been getting far the worst of the air raids during the last few months of the war. The Allies reaped a much larger toll than the enemy ever did in the early part of the war. The same as in the submarine warfare, it was a case of the biter being the most severely bitten at the finish. As far north in Germany as Trier (Treves), cities were bombed by our air forces as often as 7 and 8 times in a night. So you see, after all, the enemy civilians experienced at least some of the horrors of war.

The iron and coal mines and steel foundries around Metz, Briey and all of that wonderful rich section that the enemy had or took possession of in the first few days of the war he very thoroughly destroyed when he was beaten and had to retreat. Modern methods of mining and manufacturing are everywhere in evidence. Great furnaces, many miles of aerial railways for transporting coal and iron ore meet your eye. There is a beautiful hospital at Briey, completed five years ago by the French mining companies, to take care of their sick and injured working in the mines. You know I have a wide, rather intimate acquaintance with hospitals from San Francisco to New York and throughout the world generally, both military and civilian, and I have seen nothing superior in construction and equip-

ment to this modern French hospital. It is now functioning as Evacuation Hospital 20, commanded by Lt. Col. McHenry, who welcomed me and with whom I spent a very pleasant night. We were shipmates coming across on the wonderful transport U. S. S. Leviathan; we were mud-soaked in Pontanzen; gassed in Le Mans, and were fortunate in both being assigned to the advance sector within hearing of the barrage. This hospital has accommodations for 1,000 patients, easily extended to 1,500. The walls of the wards and rooms are 20 feet high, giving unlimited air space; windows, 15 by 5 feet, with double glass one foot apart, and steam radiators between the glass. In cold weather the outside window is opened at the top and the inside window opened at the bottom, the cold air passing over the radiator is warmed and circulates freely through the room or ward, giving a full supply of fresh air that is constantly changing and permitting an even temperature. This method of ventilation is very simple and works perfectly. We have had the ordinary winter weather in this section, the lowest temperature being about 10 degrees above zero. Modern, well-lighted operating rooms, with modern plumbing, sanitary, well-equipped kitchens, electric lights, workshops for the various mechanics to keep the plant in thorough repair, all add to the completeness of this modern hospital. Colonel McHenry took possession from the Germans a few days after the armistice.

Of course our soldiers are Americanizing the towns in which they are stationed, and a home-like feeling comes to you when you notice on the street corner Strasse Hindenburg with a black line painted through it, and underneath painted Chicago Avenue, New York Street, San Francisco Boulevard, etc. This has not been daubed, bear in mind, but lettered carefully and uniformly.

I have been in Luxembourg, that little tinsel toy nation, not much larger than a good American farm, and not as large as many cattle ranches. The city of Luxembourg is beautiful and boasts of being the wildest, gayest and most cosmopolitan city of its size in Europe. Wine, women and dancing everywhere in evidence. One of the largest public dance halls has the very familiar sign "The Hotel Chicago." This little nation is ruled by the young duchess. I was a guest at the palace one afternoon and did not feel at all

uncomfortable; in fact, rather enjoyed being in the presence of royalty. I heard a few days ago that the attractive young duchess who rules the country followed the example of many of her more democratic sisters and "ditched" her cabinet officers, general staff, royal ministers and other beautifully uniformed (their uniforms are really gorgeous) royal officials, and eloped.

The Signal Corps have charge of the telegraph and telephone service. American girls are the operators. The chief operator in Trier is Miss Lucinda Palmer, a Chicago girl, whose mother, Mrs. Martha Palmer, lives on Woodlawn avenue; Miss A. Sjostrom, Wilson avenue, is another Chicagoan; Miss Bunker of San Francisco and Miss Levy of Philadelphia and six other young ladies from various parts of the United States are living in the palace of the Princess Gotha. Miss Kreistler of Toronto is the matron in charge and it is delightful to see how well these young American girls thoroughly fit into the palace with its beautiful pictures, carpets, tapestries, cut glass and silver service. This palace was taken over for them by our government and Miss Kreistler retained the old house servants that she needed, and she tells many amusing stories of how they hid away the most valuable silver and cut glass when they first moved in and how proud they were to bring it out again when they found these American girls were to the "manor born."

These evacuating hospitals are functioning in Trier as base hospitals, and I found several of the officers on duty here that had formerly been in my command, both in the United States and in France, also some of the nurses that were with me on the Mexican border. The same high standard of professional work is maintained and, fortunately, with a great degree of comfort to the officers and nurses, as compared with the strenuous life during active hostilities. When I look back upon the work done by our medical brethren and the nurses who have come but recently from the comforts and freedom of their civilian homes into the field I feel confident that neither the profession nor the public will ever fully give them credit for the splendid work that they did, cheerfully and willingly, suffering exposure and hardship without fear or complaint. For days at a time they were water-soaked and mud-coated and cootie-infested, but they carried on, giving the best that was in them to save the sick and wounded.

Trier is rich in old Roman ruins that tradition tells us date back to the second century. Many of these ruins are still in an excellent state of preservation, such as the Porta Nigra (The Black Gate), the ruins of the old Roman baths that even today show evidence of great work and much beauty, the old Roman aqueduct and several old palaces, to please one interested in ancient history. The city is well built and kept in splendid condition. Here, as elsewhere in Europe, one is impressed by the splendid physique, manly bearing and good conduct of the American soldier.

I passed through one of the great national parks of Germany between Trier and Coblenz. Many wild deer were seen when I left the main highways in traveling across country. I was sorry that I could not take the time to call upon my old friends in the 33rd Division, Colonels Sanborn, Foreman, Davis, Clinin, and their medical officers. The regimental headquarters were widely separated and it meant too much time to see them all. My old outfit, the 90th Division, from Camp Travis, Texas, is holding a sector directly north of the 33rd Division, and I had a very pleasant reunion at headquarters with Generals Martin and O'Neil. We agreed that it was a long way to the Mexican border and still further away to the Philippine Islands, where we had all campaigned together twenty-one years ago.

I traveled along the banks of the Moselle River through that wonderful fertile valley for many miles, with vineyards covering the mountain slopes on every side. The road was like a billiard table, which made traveling very comfortable, as compared with the much-neglected roads that we frequently had to travel through the mountainous country before reaching the Moselle.

Coblenz is a very attractive city built at the junction of the Moselle and Rhine rivers, which at this time of the year, the winter snow being all melted, are both majestic streams. The city is very attractive and the stores again well stocked, the hotels and public places all crowded with our own and allied soldiers, and the people generally appear to be quite contented. Even though they are so thoroughly defeated in war, the fact that business is very good and great commercial prosperity on every hand, they apparently do not regret that they lost the war, for in doing so they have for the time being at least won commercial prosperity. We have four evacuating hospitals functioning here as base hospitals.

The hospitals are in permanent buildings, and as compared with our rapidly constructed temporary buildings and tents in the field, they are very luxurious and almost equal to well-established civilian hospitals. The medical officers, nurses and patients are very fortunate in being quartered in an attractive city where there is so much to interest them. You know most of our base hospitals have been away from the cities and towns and there has been, of course, very little to interest the personnel outside of their daily work.

Our army generally throughout this advance sector is billeted in private houses. The quarters are very comfortable and the men are able to keep themselves clean and free from cooties. Altogether, they are very contented, the health records are remarkably good and the men are in splendid fettle. Of course some of the men who are new to the military service are naturally more or less homesick and take unto themselves the full measure of the soldier's privilege of registering a grouch and grumble. Of course most of the men up in this army of occupation are professional soldiers, "hard boiled" regulars, who are very happy and enthusiastic over the service that they are now getting, for it is very much more pleasant than the Mexican border, Canal Zone, the Philippine Islands or China, any one of which they are likely to draw when moved from here. They good-naturedly "josh" the former National Guard and National Army men for wanting to go home. A detail to go to Berlin was a possibility for a couple of days, but it would not fit in, so someone else got it. Probably my turn later.

A six-hour trip on the Rhine on board the yacht of the ex-Kaiser is a delight and of great interest. Many beautiful castles are on the banks of this Rhine Valley and, like the Moselle, it is beautiful in every detail. I have been very fortunate in getting wonderful spring weather during this entire trip, which has made traveling very comfortable.

The prices are very reasonable in Coblenz; an excellent German opera company gives performances every night. Afternoon tea and dinner dances every day at the Y. M. C. A., Red Cross and Y. W. C. A. The work that the young women of these organizations are doing in Coblenz through the Army of Occupation and the entire American Expeditionary Force is of the

greatest value. Young men, young soldiers and young officers can go to tea and dance in an atmosphere that is wholesome, clean, mentally and morally, in the best possible sense. I look at this as an old soldier, as a father whose soldier sons are here, and as a medical officer who knows the penalty that a young soldier so often pays when denied this wholesome atmosphere. Enlisted men must be off the streets of Coblenz by 10 p. m.; no arms are carried by officers or enlisted men unless specially authorized.

Ehrenbreitstein, on the banks of the Rhine, is the strongest fortress in Germany, built into the mountain side; it is a second Verdun, and I presume, copied after that thoroughly tried and impregnable fortress. I am informed that 50,000 troops can be quartered in this wonderful fort that is impregnable from any direct attack. It could only be captured by running a tunnel under it and then dynamiting from below. It is an inland Gibraltar—electric lights, perfect ventilation, unlimited pure water, baths, barracks, mess halls, hospital, theater and church are all within the fortress, and, of course, now in our possession.

My return was through the Rhine Valley for many miles, one of the richest agricultural sections of Germany. There are many ancient castles on the hill sides, most of them in ruins, and one almost expects to hear the clank of armor as you walk through them. The people through this section of Germany are well nourished and clothed. One does not see a great number of overweight men that were so common in Germany in pre-war days. Hard work in the army and well regulated rations have trained them down. The heavy toll in killed upon the battle field and the great number of German prisoners of war still held by the Allies leave a great number of the physically weak in the civilian ranks.

I was able to spend a few days in Paris, and if it was not for the great number of American and Allied soldiers in uniform on the streets one could hardly believe that the grim monster of war had been knocking at the door of the city for the past four and a half years. Then enthusiasm following the great victory has helped to cheer the people and remove the gloom that existed during the war. Dr. Charles J. Koenig, a native son and graduate of San Francisco, who has practiced here for twenty years, was my host, and, with his charming wife, delightfully enter-

tained me. We enjoyed talking of our old friends and of the days when we both lived in the city of the Golden Gate.

Very sincerely,

P. J. H. FARRELL.

POLISH NATIONAL COMMITTEE

11 BIS AVENUE KLEBER

PARIS

JOHN F. SMULSKI.

THE REPRESENTATIVE IN THE UNITED STATES
UNION TRUST BUILDING, WASHINGTON, D. C.

April 24, 1919.

To the Editor:

May I ask your assistance in securing from the hospitals and other sources surgical instruments and medical supplies which we can forward into Poland for the relief of our sick and wounded civilian and military population of that distressed country?

Mr. Francis Fronczak, former health commissioner of the City of Buffalo, and now serving in Poland, has advised John F. Smulski, the representative in the United States of the Polish people, that in Warsaw and other hospitals there is an almost absolute lack of surgical instruments and supplies. He has forwarded by cable a list of articles entirely lacking, a copy of which is enclosed.

It has been thought that possibly in the various large institutions throughout the country there might be on hand surgical instruments which have been used and which might be contributed.

I am making this appeal on behalf of Mr. Smulski, and he advises me that within two weeks a ship will sail from New York to Danzig under the guardianship of Mr. Hoover, and it is thus possible to receive contributions and forward them at once into Warsaw.

The battle which Poland is making today to stay the advance of Bolshevism through the country and into western Europe is a battle for humanity, and in humanity's name this appeal is made. If you see your way clear to assist, I shall be very glad to advise you as to the destination of articles which will be sent to the outward bound ship.

Very respectfully,

JAMES C. WHITE,

Secretary.

IN WARSAW THERE IS COMPLETE LACK OF FOLLOWING
DRUGS, DRESSING MATERIALS AND
OTHER MEDICAMENTS

1. Gauze hydrophilic gauze for bandages, hydrophilic cotton wool, cotton wool, wood wool, wax cloth.
2. India rubber drainage tubes, rubber catheters, air cushions, operating rubber gloves, ice caps, hot water bottles, rubber corks and common corks.
3. Silk ligatures, cat gut, silkworm gut.
4. Clinical thermometers, injection syringes, ophthalmic pipettes, handball spray producers.
5. Surgical instruments: Knives of different shape and size, scissors, dissecting forceps, hemostatic forceps, needles, needle holders, respirators of different shape, chisels and gauges, bone forceps, intestinal and stomach clamps, different splints, retractors, hooks sharp and blunt, metallic wire for bone structure, sharp scoops, metallic catheters, trephines, paquelin cautery, potains aspirators, saws, intubation instruments.
6. Medicaments: Champhora, æther pro narcosi, chloroformium pro narcosi, calcium glycerinophosphoricum, eserinum sulfuricum, formalinum, hydrargyrum oxycyanatum salicylicum, oleum olivarum, oleum ricini, neosalwarsan, novocainum, oophorinum, varium, peptonum, agar-agar, acetone purum, levulosa, dextrosa, maltosa, saccharosa, xylolum, pituitrinum, thyreoidinum, vaselinum americanum, oleum sesami, lanolinum anhydricum, glycerinum, chininum tannicum, chinosolum, ferrum albuminatum, ferrum glycerinophosphoricum, gypsum ustum, radix ipecacuanhæ, radix senegæ, saccharinum, succus liquiritiæ, tartarus natronatus, terpinum hydratum.

Society Proceedings

COOK COUNTY

CHICAGO MEDICAL SOCIETY

Regular Meeting, April 9, 1919

1. Cancer of the Breast—Daniel A. Orth.
 - (a) Etiology
 - (b) Clinical Evidence
 - (c) Unreliability of the Frozen Section
 - (d) Elements Essential to Permanent Success
 Discussion—A. J. Ochsner, Nelson Percy and George Mueller.
2. A New Disease of the Ovaries—Emil Ries.
Demonstration of a New Tumor of the Hand.

Regular Meeting, April 16, 1919

Joint Meeting Chicago Medical and Chicago Urological Societies.

1. Cancer of the Prostate: Combined Surgical and Radium Method of Treatment—Robert Herbst.
2. What Should We Do with Tumors of the Bladder?—Gustave Kolischer.
3. Bacteriuria—Louis E. Schmidt.

Joint Meeting Chicago Surgical and Chicago Medical Societies April 23, 1919

1. Fractures and Their Treatment—Major Dehelley of the French Army.

Discussions—Dean Lewis, Arthur Dean Bevan, L. L. McArthur, D. N. Eisendrath, A. J. Ochsen, John L. Yates, Milwaukee, Wis., Carl Beck, E. Wylls Andrews, A. E. Halsted.

2. Demonstration of Interesting Work in the Application and Building of Splints—Miss Grace Gasette, American Red Cross.

Regular Meeting, April 30, 1919

1. Fundamental Principles Underlying Surgical Correction of Cleft-Palat and Hairlip—Frederick B. Moorehead.
2. Impressions of Persia—Wilber E. Post.
3. Epidemic Encephalitis in Chicago: An Analysis—A. S. Hershfield.

CHICAGO, OPHTHALMOLOGICAL SOCIETY

Meeting of Nov. 18, 1918, Continued

SPONTANEOUS HEMORRHAGE INTO THE VITREOUS

Treatment: Atrophine in both eyes, pressure bandage. Internally, syrup Feric Iodid, 30 min. three times a day. Hot applications. Referred to Nose and Throat Dept., tonsils were removed. Also given Iodide of Potash three times daily.

Discharged August 25, 1918. Condition improved. Vision, right eye 20/30, left eye 20/100.

On November 2 patient was admitted to the hospital, stating that on October 25 he had lost the vision in the left eye almost immediately. No history of any strain. Vision right eye 20/20. Left eye light perception.

Treatment: Hot applications T. I. D. K. I. gr. 10 T. I. D. Atrophine 1 per cent. T. I. D. November vision right eye 20/20, left eye 3/200.

Ophthalmoscopic examination shows extensive blood in the vitreous.

These cases are not so very rare. I have seen two of them in the past year. I had hoped that Dr. Faith would present his case of retinitis proliferans as such a condition follows these hemorrhages.

The prognosis is not good on account of these recurrences and the consequent damage done to the vitreous.

Have just had another case at the Infirmary with a specific history. Retinitis proliferans in one eye and hemorrhage into the vitreous of the other eye. Had had so many Salvarsan injections that we refrained from giving him anti-luetic treatment. When these hemorrhages are repeated serious damage is the result.

DISCUSSION

Dr. Tydings: Did this case fail to recover?

Dr. Woodruff: He recovered vision in the eye with the recent hemorrhage. I refer to the last case mentioned with specific etiology.

Dr. Mundt: What was the fundus like when discharged?

Dr. Woodruff: Retinitis proliferans in one eye. No sign

of hemorrhage except some vitreous opacities, but normal vision.

Dr. Goldenburg: Where do you suppose this hemorrhage came from? I believe many of them come from the ciliary vessels.

Dr. Woodruff: I cannot say from what vessels the hemorrhage occurred.

Dr. H. H. Brown: The case shown tonight by Dr. Woodruff is very interesting on account of the youth of the patient (twenty years) and the lack of any history that would explain the etiology. There must be, however, some constitutional cause. Dr. Woodruff has made no statement as to family history. Was there anything in the family history?

Dr. Woodruff: The family history was negative.

(To be continued)

EDWARDS COUNTY

The Edwards County Medical Society met on April 8 at Albion, and very interesting and instructive papers were read on "Carbuncles and Furuncles" by Dr. H. L. Schaefer of West Salem, and on "Influenza" by Dr. C. S. Brannon of Albion, followed by a general discussion by all members of the society. After which an elaborate luncheon was served at the home of Dr. Brannon, furnished by the wives of the attending physicians.

R. L. MOLER, Secy.

HANCOCK COUNTY

At the regular meeting of the Hancock County Medical Society held at Carthage, April 7, 1919, the following officers were elected for the ensuing year:

Dr. J. A. Miller, Hamilton, president.

Dr. R. F. Sheets, Bentley, vice-president.

Dr. C. B. Kelley, Ferris, secretary.

Dr. C. L. Ferris, Carthage, censor for three years.

Dr. S. M. Parr, Carthage, censor for two years.

Dr. J. A. Miller, Hamilton, delegate to the state society.

S. M. PARR, Secy.

JERSEY COUNTY

Jersey County Medical Society met at the courthouse in Jerseyville, April 18, and elected officers as follows:

H. R. Bohannon, president.

H. R. Gledhill, vice-president.

A. B. Curry, secretary.

H. R. Gledhill, delegate to State society.

H. F. Threlkeld, alternate.

A. B. CURRY, Secy.

JO DAVIESS COUNTY

SALUTATORY

The Bulletin of the Jo Daviess County Medical Society greets the Profession with open hands—and mouth.

We are edited by the Editor and published by the Publisher, and will be ejected semi-occasionally.

Our object in life is to put a little more pep into the Medical Society of which we are the official organ.

This we hope to do even if we have to inject with a rectal syringe.

If we don't live the allotted span of three score and ten years we shall have had the satisfaction of having been born and died, perhaps with this issue. That, you know, is about all the satisfaction a doctor has, anyway.

There are a great many things we feel like discussing—and cussing, the proposed amendment to the Medical Practice Act for instance, but owing to the fact that We expect to go through the mails We will have to forego this pleasure. However, let Us say parenthetically (how do all you sprigs of Hippocrates like being classified with horseshoers and bricklayers, plumbers and barbers?) We mean no disrespect to these gentlemen, by the way.

In politics We will go Paul one better by stating that We are all things to all men—until We get into office, and then, We are making no promises.

Should We be invited to join the much talked of League under the proposed constitution We will have to reply “nothing doing.” We will not give up an atom of Our individuality nor permit any outsider to tell Us how to conduct Our family affairs or who shall have the privilege of coming into Our house. We cannot compete with one who can subsist on a pound of rice and a dried fish.

We invite contributions from fellow horseshoers and bricklayers on any subject appertaining to the welfare of Our class and other members of the animal kingdom.

Our motto is PEP.

Our colors are GREEN.

Our pass word is DOUGH.

Subscribe for the BULLETIN by paying your dues for the last year and the coming one.

GULLIBILITY

Don't it beat the d—. No, I cannot use him. Don't it beat h—. No, that won't do, either. Don't it beat the Dutch—they will let that go—how the people fail for the fake in the healing business?

Ignorance, superstition and disease have come hand in hand down the corridors of time. The two former have been the soil upon which quacks and fakers have grown crops of dollars, and as long as these are rife among the masses there will be fakes and fakers to wax fat and harvest financial sheaves.

The ancient Egyptian had his medical priesthood, the American Indian his medicine man, who with incantations, sought to drive away the evil spirit, while in more modern times the followers of the several pseudo-medico-religious cults, with no less incantations, seek to relieve the ills of mankind.

There was Perkinism with its retractors, Wiltmerism with its magnetism, Dowieism with its effrontery and bombast, Samuelism with its eye water, Coffeyism with its absorption, and Eddyism with its egotism and fanaticism, Stillism with its dislocated vertebræ, Mechano-therpeyism with its spontaniety of thrust, Chi-

specifics, Physiomedicalism with its botanic remedies, High Delutionism with its high potency and attenuations and last but not least Mr. Shepardson's horseshoers and bricklayers. And lest we have omitted any we add “To the unknown one,” as did the ancient Greek his altar to the unknown god.

Then here comes the itinerant vendor of health restoration, representative of any or all classes from the eye glass faker with his eight day diploma to the M. D. who perhaps cannot make his living where he is known, preying on the ills and ignorance of humanity.

The poet has truly said “Vultures will feed on the eyes of kings.”

PIKE COUNTY

The Pike County Medical Society met in Pittsfield April 24, and had one of the best attended meetings in its history. About thirty members and visitors from the Adams County Society had dinner at the Pittsfield House.

The bills in the legislature, namely house bill No. 535, house bill No. 504 and house bill No. 269, by vote of the society were declared vicious and the secretary was instructed to write the legislators the stand the society had taken and that all members were opposed to these bills.

The society looked favorably upon the proposition of Dr. J. Rawson Pennington, of Chicago, recommending the Illinois Research Foundation.

The following resolutions were unanimously adopted:

RESOLVED: The Pike County Medical Society in session in the County Court room at Pittsfield, April 24, 1919, bitterly opposes the taxation of physicians \$3.00 per year as entirely unjust, in the matter of the Harrison Narcotic Law.

RESOLVED: We as physicians are taxed for the benefit of the public.

RESOLVED: We unanimously vote for the repeal of a measure calculated to tax a class for the benefit of the mass.

The following officers were then elected for one year:

Dr. R. O. Smith, Pittsfield, president.

Dr. J. E. Goodman, Pleasant Hill, vice-president.

Dr. W. E. Shastid, Pittsfield, secretary-treasurer.

Dr. T. D. Kaylor, Barry, delegate to state society.

Dr. W. F. Reynolds, Hull, alternate.

Dr. H. N. Harrison, of Quincy, then read an interesting paper on “The Unwarranted Sacrifice of the Tonsil, especially in Children.” This elicited an animated and comprehensive discussion, which was opened by Dr. A. L. Adams, of Jacksonville, and followed by many of the members.

Dr. L. S. Lacy, of Pittsfield, then presented a paper on “Weaning,” bringing out many practical points on this subject.

The society then adjourned to meet in Pleasant Hill at its next regular session.

W. E. SHASTID, Secretary.

ST. CLAIR COUNTY

The St. Clair County Medical Society met in regular session at 8:00 p. m., April 3, in the Chamber of Commerce Rooms, Murphy Building, East St. Louis, with twenty members present and Dr. Henry B. Hemenway, Chief of Division of Public Health Instruction, State Department of Health, Springfield, as a guest.

Minutes of our March meeting as published in April *Bulletin* were approved.

Correspondence relating to legislative matters was read and ordered placed on file.

Dr. R. L. Campbell, Chairman of the Public Policy Committee, presented a report recommending that the East St. Louis members of the "organized profession" manifest greater interest in civic affairs, and especially that they urge upon the Commission the importance of consulting the members of the Society as to the selection of a health officer.

Dr. Cables moved that the Public Policy Committee secure a secret ballot from every member residing in East St. Louis indicating individual preference for such health officer, ballots to be opened at a meeting to be held on Tuesday evening, April 8. Motion seconded, and after some discussion, was unanimously adopted.

Dr. Hemenway was introduced and spoke for thirty minutes on the "Public Health Problems as Relating to Physicians and the Public." He especially emphasized the importance of prompt and correct reports of births and deaths. Also dwelt upon the necessity for larger appropriations for the Health Department, and the importance of a "full time" health officer for East St. Louis.

Leonard Lee Gill, of Caseyville, and Joseph H. McGovern, of Lenzburg, were elected to membership.

Society adjourned.

C. W. LILLIE, Secretary.

Personals

Dr. Thomas A. Woodruff announces his removal from Chicago to New London, Conn.

Dr. James W. MacDonald has been elected first president of the Union League Club, Aurora.

Dr. Edmund J. Doering, Chicago, has been commissioned Lieut.-Col., M. C., U. S. Army.

J. W. Vanderslice, Captain, M. C., U. S. Army, has returned to Chicago and resumed practice.

Henry F. Lewis, Major, M. C., U. S. Army, has returned to Chicago and resumed practice.

Dr. Daniel N. Eisendrath, Chicago, has been released from military service and resumed practice.

Dr. Corey Culbertson, Chicago, announces his return from military service and resumption of practice.

Kellogg Speed, Major, M. C., U. S. Army, returned April 11 after a long term of service on the western front.

William D. Chapman, Captain, M. C. U. S. Army, Silvis, has returned from military service and resumed practice.

Dr. Frank Brawley has resumed his practice in his new offices, Suite 1119, Michigan Boulevard building, Chicago.

Dr. Joseph L. Miller, Lieut.-Col., M. C., U. S. Army, has returned from military service and resumed practice in Chicago.

Dr. Carey Culbertson has returned from military service and resumed his practice at 30 North Michigan boulevard, Chicago.

Albert B. Yudelson, assigned to duty at the Hospital La Fouché for a year, has returned to Chicago and resumed practice.

Dr. G. W. Boot has returned from military service in France and has resumed practice at 1945 Sherman avenue, Evanston.

Dr. William H. Conser, Lieutenant, M. C., U. S. Army, Cambridge, who has been in France for eight months, has been honorably discharged.

Dr. Martin B. Jelliffe, formerly of Mansfield, Ohio, who was recently discharged from the Medical Corps, U. S. Army, has located in Springfield.

Dr. J. C. Krafft has returned from France and is resuming his practice at 2705 W. North avenue, Chicago. Practice limited to diseases of children.

Payson L. Nusbaum, Major, M. C., U. S. Army, in command of Base Hospital Unit No. 12, American Expeditionary Forces, arrived in New York April 2.

Col. P. J. H. Farrell of Chicago, who has been commanding officer of two base hospitals in the advance sector in France, was recently in Germany on important special duty.

Lewis Wine Bremner, Lieut.-Col., M. C. U. S. Army, in command of the 310th Sanitary Train, American Expeditionary Forces, arrived in New York from France April 10.

Harry E. Mock, Lieut.-Col., M. C., U. S. Army, has been selected as one of the delegates for the United States at the Interallied Reconstruction Congress to meet in Rome this month.

A letter from our secretary, Capt. W. H. Gilmore, who is attending surgeon at headquarters of the advance section, U. S. Army Base Hospital 81, states that he may get back by June or July.

Dr. Ethan A. Gray, Chicago, has been appointed medical member of the District Case Board of the Federal Board for International Education, Eighth District, which comprises Illinois, Wisconsin and Michigan.

Mark Greer, Lieut., M. C., U. S. Army, Vandalia, now on duty with the British Expeditionary Forces, has been commissioned Captain, M. C., and returned to the United States and expects to be separated from the service in a few days.

Dr. C. St. Clair Drake, Springfield, director of the state department of public health, delivered an address before the Illinois Academy of Science at Jacksonville on "The Effect of the War on Science and the Responsibility and Opportunities of Science Under the New Order of Things—Medicine and Public Health."

Dr. Wladyslaw A. Kuflewski, Chicago, senior attending surgeon of St. Mary of Nazareth Hospital, was the guest of honor at the hospital on the occasion of the silver jubilee of his graduation. He was presented with a loving cup by Dr. Albert J. Ochsner, surgeon in chief, acting for the attending and visiting staff.

Dr. Orville W. McMichael, formerly director of the Edward Sanatorium, Naperville, and consulting director of the Rockford Municipal Sanitarium, and more recently medical director of the Winyah Sanatorium, Asheville, N. C., has severed his connections with the latter institution and resumed private practice in Chicago.

News Notes

—In order to permit attendance at the annual session of the American Medical Association the commencement date of Rush Medical College has been advanced from June 11 to Friday, June 6.

—The new St. Anthony's Hospital, Rock

Island, is almost completed and will be ready to receive patients early in June. The new building has been constructed at a cost of about \$240,000, is five stories in height, fireproof and contains 150 rooms.

—Although the strike of the nurses of the Oak Park Hospital was called off, two of the striking nurses are said to have filed a petition in the circuit court to have the hospital prosecuted for alleged violations of the law and to force the hospital authorities to obey the ten-hour law.

—Clinics are now being held in sixteen of the principal cities of Illinois for the free relief of children from various deformities and physical defects. The work is being done under the direction of the child hygiene department of the state, of which Dr. Clarence W. East, Springfield, is in charge.

—The medical officers on duty at Camp Grant gave a dinner April 2 in honor of the camp surgeon, George B. Lake, Col., M. C., U. S. Army, and Mrs. Lake, at which they were presented with a solid silver coffee service. The presentation speech was made by Frederick J. Combe, Major, M. C., U. S. Army, San Antonio. Colonel Lake has been transferred to take command of the Army General Hospital, Fort Benjamin Harrison, Ind.

—At the regular monthly meeting of the Kankakee County Medical Society, April 10, 1919, Lt. Col. Frederick A. Besley gave a very interesting account of his experience in the war zone of France. Col. Besley is naturally an eloquent speaker, and his address was of unusual interest because of the fact that his work with the A. E. F. took him practically over the entire western front, and those who failed to hear him deprived themselves of a rare treat.—Secretary.

—The Clinical Society of the American Hospital, Chicago, held its monthly scientific meeting April 24, with the following program:

1. Dr. F. D. Hollenbeck—"Toxemias of Pregnancy."
2. Dr. Effa V. Davis—"Treatment of Eclampsia."
3. Dr. G. G. Fouser—"Report of Case of Double Extra-Uterine Pregnancy."
4. Dr. Max Thorek—"Major Surgery in Relation to Obstetrics. Report of Cases."

Discussion opened by Dr. John J. Pflock.

—April 15 the Illinois Manufacturers' Association held a dinner and discussion on industrial surgery in connection with the Chicago Safety Council. Dr. Loyal A. Shoudy, Bethlehem, Pa., chief surgeon of the South Bethlehem Steel Corporation, spoke on "Fifteen Functions of an Industrial Surgeon," and Paul B. Magnuson, medical director of the Industrial Commission of Illinois, on "The Present Deficiency of Surgical Treatment and After-Treatment of Accidents." Dr. Leroy P. Kuhn, chief surgeon of the Illinois Manufacturers' Casualty Association, presided.

—Dr. Bertha Van Hoosen has been appointed professor and acting head of the department of obstetrics; Dr. Louis D. Moorhead has been appointed secretary of the faculty; Dr. George W. Wilson, of the Rockefeller Institute, professor and head of the department of pathology, bacteriology and preventive medicine; Ruben Myron Strong, Ph. D., formerly professor and head of the department of anatomy at Vanderbilt University, Nashville, Tenn., has accepted a similar position, and Dr. Thesle T. Job, of the University of Iowa, Iowa City, and Dr. Alden B. Dawson, formerly of Harvard, have been appointed assistant professors of anatomy in Loyola University School of Medicine.

—Dr. Frank P. Norbury of Springfield, Ill., has returned to his home and resumed private practice after having served since August 1, 1918, as Acting Medical Director of the National Committee for Mental Hygiene in New York. Doctor Norbury has served in the absence of the Director, Colonel Thomas W. Salmon, M. C. (late Senior Consultant in Neuropsychiatry, A. E. F.), and of the Associate Director, Major Frankwood E. Williams, M. C. (late in active service in the Surgeon General's office). Colonel Salmon is now on duty in the Surgeon General's office and Major Williams, having received his discharge from the Medical Corps of the Army, has resumed his duties in the office of the National Committee for Mental Hygiene.

Deaths

OSTRANDER C. POLLOCK, Shobnier, Ill.; Eclectic Medical Institute, Cincinnati, 1882; aged 79; died at his home, March 21.

STANLEY F. HESKETT, Chicago; College of Medicine (Physio-Medical), Chicago, 1887; aged 57; died at his home, March 29, from nephritis.

CLARA ANN MARTIN COOPER, Henderson, Ill.; College of Physicians and Surgeons, Keokuk, Iowa, 1898; aged 49; died at her home, about March 15.

EMANUEL SIPES, Jacksonville, Ill.; Cincinnati College of Medicine and Surgery, 1887; aged 69; a Fellow A. M. A.; died at his home, March 1, from pneumonia.

JOHN FRANCIS ABEL, Chicago; Northwestern University Medical School, Chicago, 1879; aged 61; a Fellow A. M. A.; surgeon to the Southside Hospital; died at his home, April 3, from pleuro-pneumonia.

FRANK THOMAS MCGUINN, Chicago; Northwestern University Medical School, Chicago, 1909; aged 33; was killed by the overturning of his automobile, near the boundary line between Evanston and Chicago, March 29.

WILLIAM A. COCHRAN, Danville, Ill.; Medical College of Ohio, Cincinnati, 1873; aged 68; physician of Vermilion County for seven years; died at the home of his son in Perrysville, Ind., March 16, from cerebral hemorrhage.

JAMES FORREST TODD, Chicago; Bellevue Hospital Medical College, 1863; aged 78; physician of Cook County and physician in chief for the Detention Hospital for the Insane in 1889, and city physician of Chicago, and physician in chief of the Infirmary of the House of Correction and Smallpox Hospital in 1893 and 1894; died at his home, March 24, from cerebral hemorrhage.

WILLIAM ELTON GUTHRIE, Bloomington, Ill.; Rush Medical College, 1881; aged 61; a Fellow A. M. A.; a specialist in surgery; local surgeon of the Chicago and Alton, and Lake Erie and Western railroads; once president of the Illinois State Medical Society; died in the Presbyterian Hospital, Chicago, April 6, a week after an ileostomy had been performed to relieve intestinal obstruction due to malignant disease.

MORTIMER, FRANK, Chicago; University of Illinois, 1901; aged 44; a Fellow A. M. A.; died at his home, April 21, from cerebral hemorrhage. He was a graduate of the Massachusetts Institute of Technology; ophthalmologist to Michael Reese and other hospitals; a member of the American Academy of Ophthalmology and Oto-Laryngology; editor of the *Bulletin of the Chicago Society of Medical History*; especially known for his enthusiastic interest in medical historical subjects; the possessor of an extensive collection of medical historical books, correspondence and incunabula; the author of interesting studies on "Caricature in Medicine" and on "Early Ophthalmologic Surgeons," as well as of numerous other medical historic essays. He had recently completed a translation of Choulant's *History of Anatomical Illustration* which it is believed will be of great use to anatomists, artists and art schools.

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Original Articles

PRESIDENT'S ADDRESS*

E. W. FIEGENBAUM, M. D.,
EDWARDSVILLE, ILL.

Mr. President, Ladies and Gentlemen:

The year that has just passed, began amid the turmoil of the great world war and although very remote from the actual scenes of conflict, its deleterious effects were keenly felt by all of our citizens, including the officers of the Illinois State Medical Society.

Very soon after the close of our last annual session, our secretary, Dr. Wilbur H. Gilmore, was called to the colors. After efficient service for several months in this country, he was sent abroad to serve the army in France, where he still remains. More than fifty per cent of our district councillors entered the service of our government and some of these have not as yet returned to civil life. Our President-Elect, Dr. J. W. Van Derslice, was another one of our officers who gave his time and talents to the service of his country.

We have missed these men very much in the deliberations of the executive department. We have missed the inspiration of their presence and the guidance of their advice and counsel. We have keenly felt the additional burden placed upon us by their absence and have recognized it as one of the sacrifices demanded of us by reason of the war.

More than three thousand of the medical men of the state abandoned their private interests, left home, families and friends, to lay their all upon the altar of their country, in the service of the government. Almost without exception those men were members of the organized profession of the state and they as our representatives, once more demonstrated the patriotism of our medical men.

In the president's address of last year, Dr. Coolley propounded a series of very pertinent questions in respect to the relation of the medical profession to the great conflict. The first five of this series read as follows:

1. Would the necessary number of strong medical men voluntarily enter the overseas war?
2. With what versatility would these men adapt themselves to their military duties?
3. How well would they succeed in this absolutely new field?
4. What effect would their absence have upon the profession remaining in civil life, and upon this society?
5. With how much enthusiasm and ability would those compelled to remain in civil life discharge their important duties in the selection of the army on which we were to depend for victory?

These questions could not have been answered at that time, but they can be answered in full now. Every call was answered by an abundance of men. Cities, towns, hamlets and crossroads poured out a wealth of the best talent in medicine, which on the battlefield, hospitals and cantonments proved to be one hundred per cent efficient.

But let me give you the verdict of the man best qualified to answer as to the efficiency of our medical men, because his conclusions were based upon personal observation.

The Commander-in-Chief, General Pershing, in a letter under date of February 20, 1919, commends the Medical Corps in the following words:

"Now that active operations are at an end, and many officers and enlisted personnel are preparing to sever their connection with the military forces and return to civil life, I desire to express my personal appreciation and thanks and that of your fellow members of the American Expeditionary Forces to you, and through you to the members of your Department, for the splendid services they have rendered.

*Read at Sixty-ninth Annual Meeting of the Illinois State Medical Society at Peoria, May 20, 1919.

"At the front and in the long chain of hospitals extending down to the Base Ports, I have watched the fine and unselfish character of their work, and the achievements which have added new glory to the noble profession they have so ably represented. Many of them have shared with the line troops the hardships of campaign conditions and have sustained casualties and privations with fortitude that is beyond praise. No labor has been too exhausting and no danger too great to prevent their full discharge of duty."

Just how much the doctors contributed to the winning of the war is not yet fully appreciated, but when the story of the great conflict is written, you may rest assured that the medical fraternity will be given its full measure of praise.

Now that the war is over and peace reigns over the former battlefields, our men are coming home. They are again taking up the routine of life just where it was dropped when they went away. They are coming back, eager and anxious to rebuild their professional lines and again become a part of civil life.

We, who were not permitted to go to the front, will extend to them a glad hand of welcome, assist them in every possible way to re-establish themselves in the several communities and honor them for the services rendered to our country.

The routine of practice, so much disturbed by the absence of so many of our members, must be readjusted along just lines and the returning physician must be given his former place in the practice of his profession. We must, and in all justice should, work side by side, allow brotherhood and goodfellowship to have free reign to the end that harmony in the profession may prevail to a greater extent than ever before. These men are coming back with a broader view of life, gained by their experience in the army. These men, who have looked death squarely in the eye, are not the same as when they left us. They will be an asset to this state and to the community in which they live. They will bring back something worth while, and our national life will be made better. The great lesson of the Fatherhood of God and the Brotherhood of man has received a great impetus during the past year and will be diffused all over our state with great benefit.

This great withdrawal of medical man power, placed upon those remaining behind a heavy burden which was greatly augmented by the ap-

pearance of the greatest plague that ever visited this country. Under this great stress of work the capacity of our medical men was tested to the limit and be it said to their honor, they were not found wanting. In season and out of season they ministered to afflicted humanity up to the point of human endurance, and carried into thousands of homes of the state the only ray of sunshine that entered there. It can be truly said that not all of the heroes were to be found on the battlefield.

But they are not all coming back. Nearly 500 of our professional brethren in the National Army were called upon to make the supreme sacrifice. They marched forth in the full honor of American Manhood, to the defense of their country, never to return. A lone grave, on foreign soil, now holds the one who had been the object of family affection and many a brilliant career has been cut short by the bullet of the enemy or by some wasting disease incident to camp life. Heroes, all of them, who were willing to sacrifice their all, even life itself, upon the altar of their country.

We breathe a sigh of relief as we close the door, shutting out all of the horrors of the year that has gone and devoutly thank God that He has once more allowed Right to triumph over Might and that Peace and Liberty have been assured to the peoples of the earth.

DUTIES OF MEMBERSHIP

This occasion gives us the long-looked-for opportunity to present a subject that is of great importance, and which virtually affects medical organization. What is the duty of the individual member of the county medical society and how well is this duty discharged? Year after year this subject has been discussed at the annual state meeting in the section of the Secretaries' Conference. The audience at this conference is composed, almost exclusively, of the officers of the constituent county societies, who are carrying the burden of organized medicine and, almost without exception, performing their whole duties creditably. The great body of the membership of the state society and to whom we would carry our message, is not present at this conference, and consequently we must take it up for consideration in the general session.

A great many of our county societies boast of their large membership, and proudly pay the

per capita tax on a large enrollment, but when you visit them at their regular meetings you will find only a small number present. If that visit is repeated you will be impressed by the fact that you are meeting with the same men you met before, with but slight exceptions. One society recently visited, that claims to have considerably over one hundred members, was able to secure the attendance of twenty members at the regular meeting, although a good program was arranged to serve as a drawing card. Twenty members present and over one hundred absent. Where were the one hundred absentees? Was it not just as much their duty to be present as it was the duty of the faithful few who carried the burden? There seems to be an impression in the minds of some members, that the payment of the annual dues is all that is necessary and that nothing more is required of them. This is far from the truth. If every member was of the same opinion and proceeded to put it into practice, there would be no organization. No commercial enterprise could exist if all of its stockholders refused to be interested in the conduct of the business after purchasing stock. No church or fraternal organization could continue to function, if all of its members could discharge their obligations merely by paying annual dues. No, the mere payment of money is not sufficient to keep members of this society in good standing. We need your presence in the meetings of the county medical societies. We need your influence, your voice in the discussions and your active assistance in shaping the policy of our organization.

If other argument is needed, I would suggest that it is contrary to the American spirit of fair play, to expect a few faithful souls to do the work while the rest of us sit idly by and enjoy the benefits and protection secured by medical organization. To refuse to attend the meetings of your county and state societies, to stay at home to watch the business, while others sacrifice time, talent and money for the common good is not fair, is not right. And this brings me to my next topic.

ORGANIZATION WORK

If there ever was a time in the history of medicine when good solid team work on the part of a united profession was demanded, it is right now. At every session of the legislature

the various cults and isms are hard at work trying to obtain, with the assistance of well-paid attorneys and lobbies, favorable legislation. Osteopaths, chiropractors, naprapaths, spondylotherapaths, mechanotherapaths, neurotherapaths, electrotherapaths, hydrotherapaths, suggestive therapaths, psychotherapaths, naturotherapaths, iridologists, magnetic healers, religious healers, not to mention a score of others, all trying to break into the practice of medicine by an easy method. In many instances they have succeeded in writing upon the statute books of this state, much legislation that is harmful to our profession and to the general public, and at every session they return with renewed vigor. Thanks to the vigilance and efforts of our Legislative Committee, many obnoxious bills have been defeated and the score would have been much greater if the committee had received more assistance from the members of this society. If your legislator does not hear from you in regard to the medical bills before him, he will take it for granted that these measures are acceptable and will vote accordingly. Have you told him how you feel about it? If not, who is to blame if laws legalizing quackery are placed upon the statute books of the state?

Within the last few months we have had a clear demonstration of the power in the hands of the medical profession, to control legislation. When the Department of Registration and Education proposed the annual registration of physicians, it created a most violent storm of opposition. The merits or demerits of this measure is not the point at issue at this time. The proposed legislation was condemned by the profession and this sentiment was voiced in no uncertain tones. Letters and telegrams came in by the score, in opposition to the proposed measure. County after county passed most emphatic resolutions condemning it, with the result that the bill was not presented to the legislature and, as far as this session of the General Assembly is concerned, annual registration of physicians is killed.

This is only a proof of the power of our influence on medical legislation, if we care to exert it. By a combined effort, we could, in the future, prevent the enactment of vicious legislation in any form.

We are not a power in our legislature now, solely because we do not demand to be heard

upon bills that affect our interest. We are indifferent as to medical legislation and often a bill is enacted into law before we know that such a bill is under consideration.

To illustrate the position the medical man occupies in the mind of the average legislator, let me call your attention to the fact that a representative in the General Assembly of our sister state, Missouri, introduced a bill limiting the price of a doctor's visit to \$1.50, and if called to the country, this fee could be increased by 25 cents for each mile traveled. Now the vital part of this transaction is not contained in the subject matter of the bill, but in the fact that this legislator had the temerity to introduce it at all. He would never have conceived the idea of introducing a bill limiting the charges of a plumber, carpenter, plasterer or blacksmith, but the doctor, being such an easy mark, could properly be made the victim of the whims of this country gentleman from Missouri.

Year by year we see hordes of men and some women, under some form of quackery, enter the healing profession, with a lowered standard of education, much to the detriment of the general public. The medical profession has been asleep at the switch and the crying need of the hour is to arouse the whole profession to the realization that we must be more active in politics than we have been heretofore.

COUNTY TUBERCULOSIS SANATORIA

Allow me to call your attention to the beneficent provisions of the Glackin Law recently enacted and written into the laws of our state. Under its provisions the question of acquiring a sanatorium to be used by all the people of the county who have tuberculosis, may be submitted to the voters at any general election. If results are favorable, the proper authorities are directed to levy a tax, for the purpose of erecting, equipping and maintaining a county sanatorium, which is to be used by all of the people of the county, rich and poor alike, in exactly the same manner that we now use our public schools.

Up to this time 40 counties of our state have submitted this question to the voters, and in every instance the result was favorable by an overwhelming majority. We confidently expect that those counties that have not as yet submitted this question will speedily do so, and that the time will soon arrive when every county in

our state will be in a position to offer a city of refuge to all of its victims of the Great White Plague.

It has been demonstrated beyond the shadow of a doubt that lives are saved through careful treatment in a well-regulated tuberculosis sanatorium. It has been demonstrated beyond the shadow of a doubt that scores—possibly hundreds—of men, women and children are dying in the average Illinois county because they have tuberculosis.

They are dying because there is no place for them to turn for hope of renewed health. They are dying because they have acquired a disease for which their community is responsible. Their community is responsible because it has not taken the necessary steps to prevent the further spread of that greatest of all preventable diseases—tuberculosis.

Hundreds of our Illinois men who had offered their lives for their country were stopped on the road to Berlin and sent back home because they had tuberculosis. Some of them are to be found in every county in the state. What do their home communities propose to do about it? Will they send them to sanatoria where they will have every chance for recovery, or will they refuse to extend them a helping hand?

The recent epidemic of influenza and pneumonia developed hundreds of new and hitherto unsuspected cases of tuberculosis. Many of these new cases will develop in every county. The way is open for you through the tuberculosis sanatorium law, which may be submitted to the voters at any general election. A vote for the levy of a small tax to carry out the provisions of this law is without question a vote to save the lives of many men, women and children in this state. A vote against this measure is without question a vote to condemn these men, women and children to death, without a fighting chance to live. If the measure carries—and it should—it will cost the average person in any county about the price of a good square meal once a year. What a small price to pay for the saving of so many lives!

DO YOU WANT HEALTH INSURANCE?

If so, all you have to do is to sit in your offices, watch your private interests, do nothing to advise your representatives in the legislature

how you would wish them to vote, and it will surely come.

The governor has appointed a commission to investigate the whole subject of health insurance and to make a report to the legislature now in session. Our State Health Insurance Committee has presented some very powerful arguments against the proposed measure. New York has defeated health insurance for the third time. In the general assembly, recently adjourned, the bill was defeated in the House, although it had been passed by the Senate. Ohio has voiced its disapproval, after the Ohio Health and Old Age Insurance Commission had made a favorable report on this measure. But in spite of it all, it seems that it will require the united efforts of the organized profession of the state to kill this attempt at vicious legislation.

The organized profession which will have to work under this law does not demand it, organized labor has condemned it, the employers of labor, as represented by the various national organizations, Chambers of Commerce and Civic Federations, have all gone on record as being opposed to it. It is being fostered by and originated with the "American Association for Labor Legislation," which is in no wise connected nor in any way affiliated with organized labor.

However, the supporters of this measure have a strong organization to promote its enactment, so strong that it has been successful in enlisting many prominent medical men in its defense, and it will only be by the united team work of the members of this society that it will be defeated in this state.

It is our duty to take a personal interest in this matter. Ask your representatives, either by letter or in a personal interview, to voice and vote your sentiments on this proposition, if a bill in support of this harmful innovation should be brought to their attention.

In conclusion, I desire to express my highest appreciation of the hearty co-operation extended to me by my fellow officers in the executive department and the cordial reception given me by the members of the society, with whom it has been my privilege to come in contact, during the year. They have pardoned all of my shortcomings and have given me their loyal support and assistance under all circumstances.

The honor of having held the office you gave me a year ago will be cherished, in the years

to come, as the golden spot in my medical career, and it can not be erased by any future event. As the sun is sinking into the western shadows the recollections of the events of the past year will produce an afterglow, which will illuminate the darkness of declining years.

CHRONIC PANCREATITIS.*

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CHICAGO.

We will include in this paper a brief discussion of chronic inflammation of the pancreas in so far as it is produced by infection or irritation, excluding cases of cancer, cysts and other clinical entities whose inflammatory manifestations are quite secondary in importance to the tumor mass itself.

There are five ways whereby material may reach the pancreas, and having reached it, set up the process of chronic pancreatitis.

1. From the gall bladder through the cystic and common ducts and duct of Wirsung.
2. From the duodenum through the ampulla of Vater and duct of Wirsung.
3. By extension through continuity of tissue from a gastric or duodenal ulcer.
4. Through the blood stream.
5. Through the lymphatics.

The work of Mayo-Robson, Opie and others brought into prominence the first of these. They claimed that the condition was due to the entrance of irritating material from the gall bladder and ducts. In order that this be produced some obstruction must be present distal to the opening of the duct of Wirsung. They believed this was most frequently caused by an hypertrophy of the band of Odii. It might also be caused by a fibrosis or tumor in the duodenum in this region, or by a calculus at the papilla of Vater. The direct factor in the production Mayo-Robson claimed was the irritating bile. He produced the condition by introducing chemicals and altered bile under pressure. He further demonstrated that pure bile will not irritate the pancreas, but that bile mixed with mucus from an inflamed gall bladder or other extraneous material, or if chemically altered, will do so. Archibald of Montreal confirmed some of these points.

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He used the hydrometer to measure the pressure in the gall bladder. Normally it is from 300-600 m.m. H_2O . He forced bile into the pancreas at 700-800 m.m. H_2O and produced a reaction with subsequent fibrosis. He further injected bacteria through the pancreatic duct, but found that they did not always produce an inflammation.

Clinically many cases appear to confirm their claims. The patient with the distended gall bladder and ducts containing pus or mucus with or without stones, if carefully examined, will be found to have a pancreas, swollen, firm, more or less irregular in outline and many times giving the appearance of malignancy. These cases will, as I say, appear to confirm their statements, but a more careful examination or analysis shows lymphatic engorgement indicating an infective organism, and places them in etiology group 5, that of lymphatics.

The following case is illustrative:

L. B., aged 53 years; Greek, retired merchant, complains of epigastric pain, flatulence, acid eructations, loss of appetite amounting almost to inability to eat; 20 pounds loss of weight, constipation. Stools from time to time were very light in color but now are normal. Symptoms of pyloric obstruction were thought so marked that he was brought for a gastroenterostomy and pylorotomy. Examination showed a man somewhat emaciated, muddy skin, not cachectic. A tumor in the right hypochondrium extended through epigastrium to the left of middle line. This was firm, tender, slightly movable. No tenderness at McBurney's point.

Gastric analysis showed a hypochlorhydria; bismuth meal passed rather rapidly and gave evidence of no obstruction. Urine dark amber color; Sp. gr. 1022, acid reaction, a trace of albumin, sugar negative; bile present; casts negative; temperature 99.6, pulse 76, tongue dry, coated thickly white. Diagnosis was cholecystitis and probably cholelithiasis. At operation the gall-bladder was found very large, dark and congested, full of stones and a small amount of pus. The pancreas was enlarged with a diameter about 1.5 inches. It was firm, nodular through the head and body, no signs of fluctuation; lymphatics in the gastrophepatic omentum enlarged. The gall-bladder was removed for the subacute condition and threatened rupture. Malignancy in the pancreas was strongly suspected. Patient made an uneventful recovery and left the hospital in three weeks. Tenderness almost gone; tumor appeared smaller; gastrointestinal disturbances decreasing; appetite returning and patient feeling much improved. Recent report shows tenderness gone, tumor mass not palpable. He is working every day, has an excellent appetite, and has regained his former weight. Many cases of this type which appear to be irritative

in origin from obstruction and damming back of the bile are in reality infected, as evidenced by the lymphatic enlargement, the local pancreatic involvement and the fact that excision of the gall-bladder relieves the condition.

It would appear that Mayo Robson had laid too much stress on the chemical action of the bile injected and not enough on the probable low grade bacteria injected with his bile; furthermore that Archibald had not produced the proper bed for his bacteria when he failed to introduce a traumatizing agent for them.

The second class are those cases with a weakened sphincter Odii. The fluid from the duodenum with its irritating gastric secretion, its food stuffs and very toxic contents with few bacteria, is forced up the pancreatic duct and produces an irritation. If such a dilatation were begun one would expect an early marked dilatation with great irritation and necrosis rather than fibrosis. The work of Sweet in transplanting the pancreatic ducts indicates that the band of Odii has nothing to do with protection of the ducts for, in transplanted ducts without any protection, no material appears to gain entrance to the pancreas although secretions pass out. Moreover in many cases the duct of Santorini with an unprotected intestinal end fails to carry up an infection.

The third is undoubtedly a factor in a relatively small number of cases. An ulcerating stomach or bowel if in contact will transmit its bacteria to the pancreas. It will, however, produce only a localized fibrosis and at no times an extensive pancreatitis. In some cases it would produce an acute necrosis.

The fourth factor, the hematogenous borne bacterium, deserves some consideration as a causative agent. With the work of Rosenow at the Durand Hospital on the selective action of bacteria a new light was thrown on many cases. Many theories had been set forth to explain the various neuralgias, myalgias and arthritides with which we are familiar. None of them lead to a solution through the finding of the causative factor. Rosenow brought out the information of the selective action of certain bacteria for certain organs producing certain diseases. Among these appeared the streptococcus that produced, at least, certain types of cholecystitis and pancreatitis. A further study may reveal the fact that cholecystitis is primary and the pan-

creatitis secondary, or that slightly different cultured type of streptococcus produces the latter. I believe that these cases are primarily hematogenous in the gall bladder, but they come under the Fifth group in our etiology of pancreatitis—the lymphatic. The experimental proof of this is not yet put forth. The inherent difficulties of such work have hindered its progress. The experiments of Coffee, Sweet and more recently Moorehead, however, teach us that our fear of this organ is greatly magnified and that we can do more in draining, sectioning and partially excising.

This class of cases Arhspurger and Deaver have called pancreatic lymphangitis. The lymphatics of the pancreas are arranged in three groups. The first is found along the upper and posterior surface of the body and head and drain into the glands along the superior pancreaticoduodenal artery into the glands in the gastrohepatic omentum which accompany the hepatic vessels; the second are along the lower edge of the head and body and drain along the inferior pancreaticoduodenal artery to the glands at the base of the mesenteric vessels. The third from the body and tail reach the splenic group along the pancreaticomagna branch of the splenic artery.

In the course of his studies of these, Franke demonstrated that the glands along the superior border of the head and body can be injected by pressure from within the gall bladder. This being so, the intracystic pressure suggested by Archibald and others as producing back flow through the ducts probably produces a back flow through the lymph channels and carries the infection along. Clinically, our cases confirm this opinion. Through the lymphatics the infections reach the head of the pancreas first, here it is found first and here it is best developed. If this were transmitted through the duct there would be a more uniform enlargement throughout the organ extending along the duct.

Those cases of enlargement with stones or with stoppage of the cystic duct without involvement of the ampulla, are of this class. The following case illustrates:

Mrs. H., complains of acid eructations, indigestion, much discomfort and some pain in epigastrium with a tumor mass in the right hypochondrium, muddy complexion, coated tongue, constipation, loss of weight 16 pounds. Skiagraph showed shadow over gall-bladder.

On operation we found a gall-bladder with one stone

the size of a hen's egg; no pressure on hepatic or common ducts; the pancreas slightly enlarged, nodular and firm; glands in gastrohepatic omentum enlarged. The gall-bladder was removed. Patient left the hospital in two and one-half weeks quite recovered. A recent report indicated a gain in weight and symptomatic recovery.

We have two types of pathology in chronic pancreatitis. The one predominates in the interlobular spaces and the other in the interacinar spaces. Each type begins, as do all forms of inflammation, with some exudate and infiltration of inflammatory products. In this stage we have swelling, pain, gastrointestinal disturbances, as flatulence, constipation and oftentimes a muddy complexion.

If this condition is allowed to persist we turn to the more permanent and serious type of condition with fibrosis, contraction and destruction of the secreting cells. It is at this point we separate most distinctly into one or the other of the characteristic types. In the one the fibrosis predominates in the interlobular spaces, the secreting cells are compressed and there is decreased amount of secretion. With this the flatulence, eructations, constipation and other gastrointestinal forms of disturbance grow chronic. At this stage it is difficult or impossible to produce a cure or even approximate return of health. In the other forms there is but little disturbance of the secreting cells but an involvement of the islands of Langerhans. A glycosuria is produced which is more or less permanent depending on the chronicity and in degree depending on the extent of the pathology. These two conditions may be produced in a diffuse form or in a local form and as result there may be a small or marked secretory disturbance.

In the diffuse interlobular type the pancreas is enlarged, nodular and hard while in the interacinar type it is enlarged, smooth and firm, but not hard, and seems tough and leathery. On section each presents a characteristic surface; the interlobular, with spaces surrounded and compressed by well developed fibrous tissue; the interacinar more smooth, less irregular and with less compression.

Of the associated or complicating pathology one must mention the gall bladder and bile ducts. Two types we note in these cases. The first is distended or some times contracted and thickened, filled with stones and infected mucus

or pus. The walls contain chiefly a streptococcus but sometimes also staphylococcus and colon.

The other type is the normally appearing gall bladder, either enlarged or normal in size and shape, which empties readily. It contains usually normal bile or bile and some mucus. The walls also harbor a streptococcus and possibly a staphylococcus and colon bacillus. The lymphatic glands in the gastrohepatic omentum are almost invariably enlarged and others may be found if looked for.

The treatment of chronic pancreatitis must be based on a rational consideration of the etiologic factors of the pathology present. It includes the mooted question of drainage; of cholecystectomy or cholecystostomy. The first matter is to decide on the presence or absence of obstruction at the ampulla of Vater, the degree of obstruction if any, and the obstructing factor. The second is whether we shall drain or excise the gall bladder, i. e. whether we need to, and can, get rid of the infection and exudate, through the gall bladder and ducts; or whether we must excise the gall bladder to get rid of it.

The first question being one of physical examination is usually easily disposed of. It may occur as a calculus, a fibrosed ulcer, a small malignancy or an hypertrophied band of Odii. If a calculus be found it must be removed. This is done by pressing it down into the duodenum or getting it up to an approachable point in the common duct or into the gall bladder. The obstruction by a scar, a malignancy or an hypertrophied band of Odii indicates the necessity of a cystenterostomy, for by no other means up to the present time have we as successfully surmounted the difficulty. An excision of them involving the ampulla of Vater with a portion of duodenum has not seemed a feasible operation in the human. Moorehead has performed it successfully in the dog but admits that it is much more difficult in the human. Archibald suggests a transduodenal choledoctomy at the ampulla of Vater, thereby dilating the ampulla and enlarging the opening.

The second matter is on the necessity and efficiency of drainage. This brings in the question of cholecystectomy or cholecystostomy—to drain or to excise. It is not within the bounds of time given a paper to discuss fully both sides of this question. On the one hand we have those

who like Mayo Robson, Opie and Flexner backed up more recently by Archibald and others who contend that the pancreatitis is a chemically produced reaction and that prolonged drainage is essential to its relief if not its cure. They recognize the fact that the infiltration may be far reaching, deep seated; that it may have gone beyond the mucosa but they maintain that if drainage is kept up for weeks or months in the more severe cases the condition can be cured. They do not acknowledge that these are infected cases and that they are not usually successfully drained. Unfortunately, they have no criterion whereby one may know that the infection has ceased and the condition is cured. It has been said, and rightly so in most cases, that the fistula will close and remain closed only when the inflammation is gone. We have all had this experience from time to time, but no one cares to carry patients through it.

On the other hand we have those who believe in the infectious origin of the condition, that it is lymphatic borne from the primary focus in the gall bladder, and that the only way to get rid of the condition is by an excision of the primary focus. We must not confuse these cases of gall bladder wall infections of strepto with those of empyema of staphylo and colon types. This last group can be best treated and cured by drainage but it is a very small group and does not often produce pancreatitis. Clinically, we find that excision is the only method of treatment. The following case illustrates:

G. H., aged 28 years, complains of pain in epigastrium; tenderness in midline, pain in the right iliac fossa, some tenderness on deep palpation; acid eructations, constipation; normal appearing stools, no jaundice, some muddy complexion if constipated; some pain in right hypochondrium. I operated through high appendix incision; appendix removed. Exploration of the upper abdomen showed the gall-bladder containing a number of stones, the pancreas somewhat nodular and thickened. I removed the stone and drained the gall-bladder through a puncture wound for three weeks, when it closed, only to open and close again and again for some seven weeks. Three months later he was back complaining of the old epigastric pain. On operation I found the gall-bladder attached to the wall, somewhat thickened, the pancreas was still thickened and nodular. I removed the gall-bladder, tied off the duct and inserted two cigarette drains. Patient left the hospital in two weeks. He has just returned from France and says nothing distresses him; he has no pain. The patient was not aided by drainage, but apparently cured by excision.

Another type of case is that with a gall bladder distended with stones, mucus and bile:

Mrs. G., aged 71 years, presented a history of the usual symptoms incident to this disease. At operation the gall-bladder was very dark and congested, the pancreas nodular, firm and enlarged. The lymphatics in the gastrohepatic omentum enlarged. I excised the gall-bladder and drained down to the duct. Recovery uneventful; gastric disturbance ceased. At present she is doing the housework for a family.

The third type is the normal appearing gall bladder which empties with difficulty, is slightly thickened and contains a dark, viscid bile:

Mrs. S., aged 28 years, gives a history indicating a gastric ulcer, the symptoms of which have subsided. She has, however, epigastric distress and eructations. Some right hypochondriac tenderness running across to the left side. Barium meal indicated a healed ulcer on lower anterior surface of stomach greater curvature. At operation we found a long gall-bladder full of dark viscid bile, the pancreas slightly thickened, firm and nodular. I performed a gastroenterostomy to relieve the slight pyloric stasis and a cholecystectomy. Recovery uneventful. Symptomatic cure.

These cases we have been accustomed to drain after excision. Recently, we believe that they are better without drainage provided we have secured and sterilized the cystic duct stump, and that we have no oozing of blood or bile from the under surface of the liver. We have less adhesions, less likelihood of our ligature slipping and no danger from tube or gauze eroding the intestine.

The patient with the prolonged case cannot hope for a removal of the fibrosis nor of any improvement in the glandular portions of the organ injured by the fibrosis. The only improvement can be expected from removing the exudate before organization has occurred. This will relieve pressure and permit of a partial return to normal of the cells. As a result of this we can expect an improvement in the digestive ferments and in the internal secretion from the islands of Langerhans. This, the thing to be desired, should prompt us to an early diagnosis and to an early surgical interference for the best possible results.

CONCLUSIONS

1. Chronic pancreatitis may be irritative in origin, but is usually infective, being lymphatic borne from a primary focus in the gall bladder.
2. Cure for it consists in removing the primary focus and permitting the natural resources of the body to take care of the damage.

3. In the late stages with marked fibrosis only a stopping of the process may be produced while the existing fibrosis can by pressure continue its damages.

4. Early diagnosis and early removal of the primary focus to prevent fibrosis is important.

5. The doubtful case of gastric disturbance should be looked into very carefully as early as possible to save it from the chronic fibrous stage.

THE USE OF THE TINCTURE OF IODINE IN INTENSIVE DOSAGE IN THE TREATMENT OF TUBERCULOSIS AND OTHER INFECTIOUS DISEASES.*

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CHICAGO.

Historical Note: It is now more than one hundred years since the discovery of iodine; namely, in 1811, when Courtois, a soap maker of Paris, engaged in the manufacture of soda from the ashes of sea plants, obtained a waste liquor entirely different from anything which he had ever observed. This greatly attracted his attention, and, being of an observing mind, he submitted it to the French chemists Clement and Gay-Lussac, who successfully isolated from it a new element which, owing to its violet vapor, was called iodine. Minute quantities of iodine are found in sea water, and marine plants possess the power of abstracting and accumulating it as organic salts in their tissues and from these dried and partly incinerated, or half vitrified, sea weeds iodine is prepared. This so-called ash obtained from these sea plants is commercially known as kelp, and until the discovery of iodine in Chile saltpetre was the chief source of this drug.

Physical Properties, Tincture of Iodine: Iodine is readily soluble in alcohol, ether, chloroform, in bisulphide of carbon, in the various fixed and volatile oils, and slightly in water—about 1:7000—but we physicians are concerned with iodine chiefly as a drug when dissolved in alcohol in proper proportions, and which is then known as the tincture. The tincture of the U. S. P. is a 7 per cent. iodine solution in 95 per cent. alcohol, containing 5 per cent. of potassium iodide. The tinctures of the French Pharmacopeia, an iodine solution, one part iodine in

*Read February, 1919, at the meeting of the West Side branch of the Chicago Medical Society.

twelve parts of 90 per cent. alcohol, and that of the German Pharmacopeia, one part iodine in ten parts 90 per cent. alcohol, are more desirable for an iodine impression and this is owing to the absence of iodide of potassium in these tinctures, which in some individuals is found to be extremely irritating. The National Dispensary, a commentary of the U. S. Pharmacopeia, describing iodine and its properties, states, among others, that it is a gastro-intestinal irritant of intense severity said to produce diarrhea, vomiting and collapse, but still that death has rarely occurred, and that if death does not result from acute gastro-enteritis, secondary fatty degeneration of various organs may occur; that iodine is given internally to a limited extent in the form of the tincture in two or three minim doses, that the most common use is in the dose of one-fourth to one minim. In case of so-called poisoning the proper antidotes are also mentioned. Commenting on the above, it was not at all surprising that when I began prescribing the tincture and gave it in twenty, thirty and one hundred drop doses, many a cautious druggist, on looking up the dose in this recognized and accepted standard book, called me up by telephone when a tincture of iodine prescription was presented for compounding, enquiring if I were not mistaken as to dosage. In several instances the filling of the prescription was simply refused, one druggist remarking to his customer that if he took thirty drops of tincture of iodine, as was stated on the prescription, that "in three days his friends would walk behind him."

Tincture of iodine has been administered in extremely large doses by many internists and most particularly those of the French school. Dr. L. Boudreau of Bordeaux, France, has given tincture of iodine very systematically for years in pulmonary and other forms of tuberculosis, pushing the remedy to tolerance. He says: "It is indicated wherever there is infection. Iodine is a natural component of the body; does not accumulate, is rapidly eliminated, is both microbicidal and antitoxic; a tonic to the human organism and the vital functions; stimulates the production of leukocytes, produces hyperleukocytosis, increases functioning of the glands, especially the ductless. Indicated wherever fever develops, in all inflammatory conditions, in septicemia, in typhoid and typhus, in puerperal fever, in meningitis, measles, scarlet fever, whooping

cough, pneumonia, etc." I have given tincture of iodine internally for a number of years, usually in progressively increasing dosage, and I am fully convinced of its beneficial, inhibitory and curative effect. Iodine may be administered with most favorable results in all diseases due to the action of bacteria; even in small doses it possesses highly bactericidal properties. In cases of pus formation with a tendency to absorption, for the removal of an inflammatory exudate, in acute or chronic pleurisy, in tuberculous peritonitis, both ante- and post-operative, in pulmonary tuberculosis at any stage, in chronic fibroid phthisis, in glandular tuberculosis, in unresolved pneumonia, as well as in the acute stage; in erysipelatos inflammations, in multiple abscesses, in osteomyelitis, etc.

How to Administer Iodine: For the administration of tincture of iodine various vehicles have been used. Some advise it to be given in water, in cider, in root beer, in wine, in coffee, in plain beer or in liquor, but the vehicle most suitable and one which I have recommended for the administration of either large or small doses is ordinary good and wholesome milk. Beginning with a single drop in about one-half glass of milk at the first meal, two at the second, three with the third, and so on until a dosage of twenty or thirty drops has been reached. This amount may then be given three times a day, best with or right after the meal, and continued for some time. Now, if it be desired to increase this dose, then the gradually increasing drop method should be resumed until fifty, sixty, one hundred or more drops are given, and when the highest single dose desired has been reached it should then be given three times a day. Should, however, an individual's idiosyncrasy show an iodine intolerance, then the dosage should be lessened, or for a time entirely suspended. Personally, I have never observed a single instance of intolerance, nor of iodism, nor any untoward effect, no systemic or organic disturbance, nor any so-called toxic or deleterious effect during the entire period of iodine administration. It is said that in some individuals an iodine intolerance or iodism is brought about if the drug is administered in small doses, but that if it is then pushed to larger dosage all disturbing symptoms disappear. Perhaps by increasing the dose so rapidly, as I have done in following the drop method, I have avoided all such iodine disturbances. As the dose

is gradually increased, if it be desired to lessen the amount, then the gradually decreasing drop method should be resorted to, lessening one drop with each meal.

IODINE IN TUBERCULOSIS.

I have for many years prescribed the U. S. P. tincture of iodine in progressively increasing doses in the various forms of tuberculosis that come under my observation and have become thoroughly convinced and much impressed, as stated above, with its helpful, serviceable, and yet harmless action when properly and intensively administered.

I have administered tincture of iodine in large doses in tuberculosis of the mediastinal glands, given to children up to the age of four years, twenty drops three times a day. I have given it in many cases of bone and joint tuberculosis. In a number of cases of pleurisy with effusion when the effusion was either small or when no attempt was made at aspirating, the ingestion of iodine was invariably followed by amelioration of all symptoms of distress; also in tuberculous sinuses, and most particularly have I given it in pulmonary tuberculosis in all, any and every stage. The enumeration of many case histories may be of no practical purpose; however, a few histories showing the result of persistent and intensive iodine medication should engage our attention, after which it might interest you all very much to know what effect the administration of iodine has on the sputum flora of the actively tuberculous:

Case 1. Miss Julia D., aged thirty-four, gives the following history: At the age of seventeen, in 1902, a number of glands were removed from both the right and left sides of the neck, which is evidenced by scar tissue above the clavicles near the sternal ends. At the same time the glands in the left axilla were removed, although at the time she did not know that they were enlarged. She also had rectal abscesses and fistulae which were operated on at the same time, but would not heal and continued for many years to give her much discomfort. About ten years ago, in 1908, an abscess appeared in the right groin. This was lanced and it also would not heal, but continued discharging pus until last year, in the spring of 1918; since then it has remained entirely healed. Previous to that time many attempts at healing were made, but all without success; the repeated injection of Beck's paste would cause a closure only for about ten days, after which it would reopen. She lost much weight, became emaciated, and in the fall of 1912 she was sent to the Oak Forest Tuberculosis Infirmary as an incurable and hopeless case. While at Oak Forest the rectal

fistulae and abscesses gave her much pain. She was advised to see me and consulted me for the first time as a clinical patient at the Rush Dispensary early in 1913.

She was admitted to the Presbyterian Hospital and was operated on by Dr. A. D. Bevan on April 1, 1913. The rectal operation was most successful. However, the fistulous opening in the groin would not improve and she was informed that nothing more could be done. She left the hospital in fairly good condition, and as the discharging abscess at the groin did not cause her much discomfort she sought employment in a large mercantile house, where she has been employed ever since.

I now began treatment to heal, if possible, this continually discharging sinus below Poupart's ligament, the remains of an old, chronic psoas abscess. The discharge was very profuse, but by simply applying a few thick layers of absorbent cotton, held in place by a suitable bandage and replaced three or four times each day, she was made quite comfortable. No previous medication was given, but for a short time fairly large doses of tuberculin were administered by the then, by me, so much favored vaccination method; this seemed to be of little or no benefit, and the intensive iodine treatment was begun.

Beginning in the fall of 1913, with the usual drop method, increasing to thirty, then to sixty drops three times a day, I noticed after many months of medication that the discharge became less in amount. Her health steadily improved; being employed during the day she found it most inconvenient to take the noon-day dose of iodine at her place of employment and, without consulting me, she then took eighty drops of tincture of iodine after her breakfast and eighty drops more after her evening meal. That is, eighty drops twice a day, or 160 drops in all. The discharge gradually became less and less, continuing in the treatment, when in the spring of 1918 the fistulous opening closed and has remained closed ever since. However, at my suggestion, she continued the iodine treatment during the summer, discontinuing and suspending all further medication in the fall. Now for more than nine months the fistula has remained healed, she is in perfect health, is at her post of duty every morning, and in the five years of taking iodine she has lost, save for her vacations, not a single day. She began the intensive iodine medication in the fall of 1913, continuing it uninterruptedly until the fall of 1918, or for five years, displaying at no time any iodine intolerance or iodism, or any disturbance attributable to the administration of the iodine.

Case 2. Loretta O., in September, 1912, at the age of nine years, came to the Rush Dispensary giving the following history: Enlarged cervical gland since the age of two years. Measles and whooping cough at five, since which she has had occasional dyspneic attacks, becoming more and more marked, with orthopnea. Cervical glands were much enlarged, especially the left, extending down to the clavicle; epitrochlear palpable, tonsils slightly enlarged, and over the upper chest the veins and venules were very prominent, sug-

gesting intrathoracic gland hypertrophy. Over both the upper and lower extremities numerous purulent papules and crusts were noticeable. The lungs were negative. The tentative diagnosis was adenitis with suspected lues. She was put on pil. protiodide one-eighth grain and syr. ferrous iodide one-half drachm three times a day, without perceptible improvement. She was referred to the dermatological department, where her skin lesions were diagnosed as tuberculides, folliculitis and acnitis. The tuberculin test was positive, while the Wassermann reaction was strongly negative. Owing to the persistent cervical gland enlargement she was referred to the tuberculosis section for treatment, where for more than a year she was given in addition to the indicated constitutional treatment appropriate doses of tuberculin, but observing no change in the size of the glands and the skin lesions becoming more and more extensive as well as painful, she was put on the tincture of iodine medication in 1914, and continued almost uninterruptedly until 1918, taking at times for months forty drops of the tincture three times a day.

Now for more than a year the skin lesions have remained healed, the extremities are much scarred from the extensive and persistent tuberculides, the glands about the neck are much reduced excepting on the right side below the angle of the jaw where there still persists a large but not painful group. This girl, now fifteen years of age, is in perfect health and for more than four years has taken almost daily and with little interruption a dose of tincture of iodine ranging from sixty to one hundred and twenty drops.

And now let us for a few moments consider what effect the administration of tincture of iodine has on the sputum flora.

The Sputum Flora Under Iodine Medication.—If we examine microscopically the sputum of an actively tuberculous individual previous to the iodine medication, we will find that accompanying the tubercle bacillus are the bacteria of mixed or secondary infection, the staphylococcus, micrococcus catarrhalis, pneumococcus, streptococcus, etc. Now if we begin the administration of iodine, continue this medication, and after we have reached a dosage of thirty to sixty drops and have maintained it for some time we then secure another specimen of this patient's sputum, we will note a decided change in the sputum flora as compared with the first specimen. We note no change in the number or appearance of the leukocytes, lymphocytes or epithelial cells, but a distinct change in the secondary microorganisms, and this is that the bacteria of mixed infection have nearly all, if not all, disappeared, and this is not the only change noticeable in the smear, for the tubercle bacilli themselves seem to have undergone some modification, and from a well

stained, distinctly outlined and readily recognizable bacillus seen in the first smear, we now observe in the second a scrawny, poorly stained and often beaded bacterium. In some specimens I have noticed a distinctly granular appearance of the bacillus, showing but a faint outline of the organism; in others spore-like bodies appear at either pole, or in different parts of the body, suggesting strongly that the bacillus under the iodine impression is perhaps undergoing some retrogressive change.

IODINE IN ERYSIPELAS.

My attention was directed to a peculiar incident in the medical literature. A physician attending a patient suffering from facial erysipelas prescribed tincture of ferric chloride to be administered in thirty drop doses three or four times a day, and on the following day was greatly surprised to find his condition so rapidly improved. In the course of the conversation between the physician and the patient the latter remarked that the medicine was all right, but that he could scarcely take it because he found it so irritating. The physician, upon examining the vial, found that tincture of iodine had been dispensed in place of tincture of iron. However, he was so much impressed with the rapidly good results that in the next case of erysipelas which came under his care he resorted to the iodine medication at once, and again he was agreeably surprised by its prompt effect. I can speak from personal observations for the positively specific value of the iodine treatment in erysipelas, when given in milk in twenty to thirty drop doses every three hours.

Dr. W. A. Evans, former Commissioner of Health of this city, some months ago requested that I send a copy of a paper on iodine which I read before the National Tuberculosis Association at their meeting in Washington two years ago, in 1916, to Dr. L. S. Rogers, Superintendent of the Mississippi State Charity Hospital at Jackson, Mississippi, and from his letter to me I may quote as follows:

Your notice on page four in regard to the treatment of erysipelas with tincture of iodine is a good quotation of a part of a report I made to the *New York Medical Record* on this subject nearly three years ago.

Without going into details will state that about fifteen cases of erysipelas have been treated in this hospital with large doses of tincture of iodine with the

most prompt and signal relief in every case except one, and this case, a large, plethoric woman with erysipelas in the nose, died on the second day of admission in uremic convulsions.

We have tried large doses of tincture of iodine in the treatment of pellagra with seemingly good results. Of course, we did not neglect the diet. We have now in this hospital a woman of about fifty-five years of age having a typical case of pellagra. She has been taking fifteen to twenty drops of the standard tincture of iodine for three months without special diet. The skin eruptions on neck and hands have been relieved and she is in fairly good condition. The results are not so striking as in erysipelas.

The St. Louis City Hospital reports the treatment of three cases of idiopathic erysipelas with large doses of the tincture of iodine with splendid results.

I am thoroughly convinced that iodine is a specific in all forms of idiopathic erysipelas, and I am also convinced of another fact, that the tincture of iodine can be given for long periods without any deleterious effect.

In this connection I wish here only to allude to the generous effect of the administration of the tincture of iodine, both as a prophylactic and a curative measure, in the present epidemic of influenza when given as a preventive in the dosage of ten drops three times a day, and as a curative in twenty to thirty drops every three hours.

CONCLUSIONS AND DEDUCTIONS.

We can infer from these observations that iodine may safely be administered in extremely large doses and for long periods of time without anticipating any deleterious effects.

Iodine is perfectly innocuous and non-irritating to the gastric mucosa if given in its proper vehicle, good, wholesome milk. Further observations have also proven that beneficial and lasting results only follow the ingestion of large doses of iodine, and that for curative effect the use of small doses is not dependable.

When iodine is administered its presence can readily be demonstrated in the various fluids of the body, both excretory and secretory—the urine, saliva, etc.—within fifteen minutes, and nearly all, excepting perhaps a slight trace, will have again disappeared in a few hours. Iodine should be given persistently and in large doses, to saturate the body, in order to inhibit bacterial growth. As iodine is innocuous to the body tissue, but is largely destructive and inhibitive to all microorganisms, its proper use cannot be followed by any harmful results to the human economy. We find, particularly in tuberculosis, that the administration of iodine is a most rational

procedure. We all know that in tuberculosis the lymphocytes play a most important part in the process of immunization. The administration of iodine is followed by a lymphocytosis, that is, more lymphocytes, but lymphocytes produce a fat-splitting element; hence, a lymphocytosis increases this element, increases this lipolytic ferment which possesses the power of separating the body parts of the tubercle bacillus, this stimulates the production of the defense agencies and consequent immunization.

It also has repeatedly been observed that if to a tuberculous individual intensive doses of iodine are administered for some time his tuberculin sensitiveness disappears as far as its concerns a rise in temperature. This effect seems to depend upon the reduction or lessening of the temperature producing tuberculotoxic substance in the body.

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THE IMPORTANCE OF THE ANAEROBIC BACTERIA TO MAN.*

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It was with considerable hesitancy that I accepted the invitation of this Society to address it on the subject of anaerobes, knowing as I did the splendid work of the bacteriologists of Chicago in advancing our knowledge of the subject. The great importance of the anaerobic bacteria was accentuated during the war and having had the opportunity of working in France on the bacteriology of war wounds for eight months in 1916-17 I was impressed by the frequency of the infection with these microorganisms and my interest in the whole subject was reawakened. Many new anaerobes have been discovered and our knowledge of others has greatly increased. Moreover, the technique for study has been much improved and the means of identification made more easy. I have, therefore, undertaken to tell you in the briefest way possible, some of the important and interesting new facts about the anaerobes.

Like almost every problem in bacteriology we must go back for its beginnings to the illustrious Pasteur who in 1861 noted that butyric acid fer-

*Read before the Chicago Medical Society, March 12, 1919.

1. From the Pathological Laboratories, University of Pittsburgh.

mentation was due to a microorganism which lived without free oxygen. He believed that putrefaction was also the result of the growth of these bacteria to which he gave the name anaerobes, a view which has since been amply confirmed. In fermentation the anaerobes play an important part and at one time the importance of this question to man would have been given almost the first place. But with the passing of fermented beverages it must receive no more than this brief notice.

The anaerobes take such a large part in the processes of nature that we might well stop and consider them in the life cycle of our planet, the breaking down of organic matter into the substances available for plant life. The story of the septic tank, the confusion which arises from anaerobic lactose fermenters in the presumptive test for *B. coli* in water, the study, developed in this country, of the bacteriology of canned foods, botulism and its anaerobe, and many other similar subjects would be of interest and fulfill many of the requirements of my title but I am going to confine myself to a necessarily brief discussion of the more intimate importance of this very large division of microorganisms to human beings.

What is an anaerobe? The definition of Pasteur (an organism which lives without free oxygen) still holds good, but it needs clarifying and has led through misinterpretation to much confusion. It is not so much the absence of oxygen as it is the form and amount in which the oxygen is made available to the organism that determines what we call anaerobic conditions for growth. It has been frequently shown and almost as frequently forgotten that conditions in our test tubes, which at first sight would not appear to fulfill anaerobic requirements, suffice to grow these bacteria. Oxygen is perhaps the first necessity for life but the amount needed varies with different forms of life. An excess overstimulates the vital activities and death results from actual combustion. Many bacteria which grow in the free atmosphere will do better with a lessened amount of oxygen under semi-anaerobic conditions, that is, they do better, with a lessened amount of stimulus.

The bacillus of acne and a great many other anaerobes grow more luxuriantly in solid media just at the zone where the oxygen being absorbed

is suited to their needs. It is remarkable how many strict anaerobes prefer this zone and colonies often grow much larger at this point than they do in the deeper, more strictly anaerobic, zone. They unquestionably come in contact with the absorbed oxygen. You know it is exceedingly difficult to obtain conditions where every trace of free oxygen is absent and it is not necessary to do so. We are prone to explain our failures in obtaining growth of anaerobes by saying that we were unable to remove all the oxygen from our media when the truth often is that we have not supplied the bacterium with the proper food material. Nevertheless there are many anaerobes which demand very strict methods of oxygen exclusion.

Another very important point to remember is that even microscopic areas under anaerobic conditions are sufficient when the food factors are correct, to initiate the growth of these bacteria. Once started they produce about them the conditions they need. The *B. welchii* in a deep dextrose agar will on occasion saturate the agar with its gas without forming bubbles and the bacillus under these conditions grows right to the surface of the agar, it being very common to find the fluid forced to the top, white with growing organisms. Excellent surface growths of this and other anaerobes can be obtained as follows. Invert a slanted tube of medium such as coagulated serum into a larger tube of a fermentable fluid medium as milk, allow the air contained in the first tube to be removed in the sterilizer which will then become filled with the milk. After seeding, the gas formed in the fermentation will collect in the serum tube. The surface growth then follows in the gases produced by the organism itself.

The mechanical exclusion of air after prolonged heating of the media is probably the most frequently employed method of obtaining anaerobic conditions and the consistency of the medium determines how rapidly air will be reabsorbed. The cooked meat medium, of which I shall have occasion to speak further, largely depends for its efficiency on the slow reabsorption of air after heating, especially within the zones about the meat particles. Wright has explained this and other similar media in open tubes, which give anaerobic growth, on a basis of mass action but I believe it is due to mechan-

ical interference to reabsorption of air by the surface tension surrounding the small particles.

Mixtures of certain anaerobes with aerobes will at times grow well in open broth tubes and in colony symbiosis on the surface of aerobic solid media and here indeed the free oxygen is very close. This latter has been used to isolate spore-bearing anaerobes by Sturges and others and I have found it useful for a few anaerobes. I do not wish you to believe, knowing these facts, that these are not anaerobic bacteria at all but rather to show you how slight the necessary conditions may be. None of the anaerobes I am considering grow in pure culture on the surface of solid media exposed to the air.

All this may appear very far afield from my subject but I hope to show that these few points have a direct bearing on many of the problems of infections with anaerobic bacteria and their presence in and on the human body.

A tremendous amount of work has been done on anaerobes but the mass of it has been of a special nature and we have not yet come to the place where anaerobic bacteria are studied in the routine bacteriology of our laboratories and therefore our statistics are comparatively meagre and our interpretation must be conservative. This is due to the difficulties of technique. The time consuming methods of isolation largely precludes its being adopted for general use and the anaerobes are neglected unless for some reason or another we suspect their presence. The cooked meat medium will give us evidence of anaerobic bacteria being in our material many times when there would otherwise be no suspicion of them and thus would serve to stimulate the bacteriologist to determine their type. The almost universal occurrence of aerobes which are facultative anaerobes adds to our confusion and difficulties. The next important check in such studies is the lack of convenient methods for more or less rapid identification of the bacteria which have been recovered, and isolated anaerobes are apt to collect on our shelves unclassified and therefore add but little to our knowledge.

I wish to mention these difficulties because, when claims are made for the etiological importance of anaerobic bacteria in many disease conditions, the vast majority of the profession are quite unable to pass judgment. In bacteriological work nothing is more important than the realization that the flora developing in our test

tubes is determined by the conditions we offer to favor the growth of the particular groups of microorganisms. Plain broth will give a predominance to certain forms, serum broth to others, addition of blood to still others, acid media to the acidophilic types, partially digested protein media to many groups and anaerobic conditions will alter all these. These are very real difficulties and the development of special media has tended to decrease and at times to increase dogmatic statements. When we are interested in any particular group we endeavor to eliminate all others from our cultures and the psychology of this procedure is to overemphasize the importance of our findings.

With these preliminary considerations in mind I wish to take up a few points about the anaerobic bacteria in relation to man. Anaerobes about the mouth and respiratory tract. The most familiar organism with anaerobic characters in these regions is the *B. fusiformis* which is found in such numbers in Vincent's angina and other ulcerated conditions in the mouth cavity, in the diphtheritic membrane and in pyorrhoea and abscesses about the teeth. I have grown it in almost pure culture from such an abscess. Noma frequently shows this anaerobe but on two occasions I have grown *B. bifidus* from typical noma cases and they were present in overwhelming numbers. Caries of the teeth has undoubtedly associated with it anaerobic bacteria which if not the actual cause are of importance in continuing the process. The anaerobes isolated by Tunncliffe in acute rhinitis (*B. rhinitis*) and chronic bronchitis are of great interest and resemble in certain points the *B. anaerobius gracilis* and the *B. helmenthoides* described by Lewkowicz from the mouths of infants in Cracow. The anaerobic micrococcus obtained by Tunncliffe from the blood in the early courses of measles is of great importance. I have not had an opportunity to confirm her findings. Strict anaerobic Gram positive cocci are quite uncommon. Dick and Henry (1915) have found many types of anaerobes in the respiratory tract of scarlet fever cases.

I have recently isolated a very interesting anaerobe out of material from the mouth (tonsillar swabs and sputum) in the last five attempts. The patients were suffering from tonsillitis or tracheitis, one had had influenza two months before and was practically normal, being

in bed on account of a heart lesion. The material was cultured on a variety of media including cooked meat, and numerous mouth bacteria were isolated. I was looking for *B. influenzae* and in some of the primary mixed cultures, especially from the meat, smears showed numbers of tiny gram negative bacilli or cocci. *B. influenzae*, however, was not obtained. The meat medium was foaming with gas and suspecting an anaerobe from my experience in war wound cultures, I was able after many attempts to isolate the cause of the foaming in the shape of a tiny, strictly anaerobic, coccoid bacillus often in flattened pairs and groups. It would appear that the organism I have found is probably the *staphylococcus parvulus* described by Veillon and Zuber and several others. It is called by Lewkowicz *micrococcus gazogenes alcalescens anaerobius* and is found in the mouth. Russ (1905) described an anaerobic bacillus like *B. influenzae* from a rectal abscess, but no mention is made of gas production. The anaerobic surface colonies are, however, very like those I have found. Dick and Henry found similar anaerobes. I have called attention to this anaerobe because its significance is undetermined and it is liable to be confused in mixed aerobic cultures with the strict aerobe *B. influenzae* and further to illustrate that anaerobes are present in the material we study which are not suspected when ordinary media are used.

Many other anaerobic bacteria are to be found in these regions leaving out the spirochaetes and the spirilla forms but enough has been said to indicate that even in the respiratory tract where the conditions of anaerobiosis would appear to be relatively shallow anaerobes are frequently if not always present. Infections of the respiratory tract and the bacteriological findings in them are, to say the least, confusing and comparatively little attention has been paid to the anaerobic flora in attempting to clarify the situation. In the sinuses of the head, the middle ear and abscesses of the brain, anaerobes are not infrequently found. They are also met with in pleurisy and in the lungs. The stomach with its acidity of 0.5—0.2 per cent. allows many bacteria (acid resisting forms and spores) to pass through and under abnormal conditions we have the lactic acid bacilli or the Oppler Boas group which are almost anaerobes. *B. bifidus* and

similar forms have been grown from the normal stomach.

The anaerobes of the intestinal tract make a study by themselves and a tremendously difficult one it is. Dr. Kendall has done so much valuable work along these lines that I hesitate to speak on a subject you are probably familiar with. However, very briefly the most interesting points are as follows: The diet largely determines the bacterial flora of the intestine. In breast fed children the *B. bifidus*, a strict anaerobe, is the predominating organism. This bacterium produces large quantities of acid giving rise to the normal acid stools and which acts in a helpful way in more or less sterilizing the intestine at this early period of life and in stimulating bowel movements. As the diet increases in variety the flora changes until it becomes the most complex picture of bacterial forms known to bacteriologists. The anaerobic flora of man includes a long list of important bacteria but it would be tiresome to recite them. The most important are the *B. welchii*, *B. sporogenes*, *B. putrificus*, *B. bifermentans*, *B. tertius* and many others. Whether the *B. oedematiens* and *vibrio septique*, as we understand the latter today, are to be found in the intestinal tract of man I do not know but I would consider it very probable. Ghon and Sachs recovering an organism, now recognized as *vibrio septique*, from a case of gas gangrene following perforation of the intestine would indicate its presence in the bowel. These anaerobes, including the last two, have all been found in war wounds in the present war, and I will discuss them later.

From a technical standpoint there are numerous difficulties in isolating many of the anaerobes and especially non-sporing forms from intestinal contents. The *B. welchii* and *B. sporogenes* are probably the easiest to separate. An interesting point in the study of *B. welchii* is the regularity of its producing spores in the intestine and the difficulty of forcing it to do so in our test tubes. The results in determining *B. welchii* in the feces are almost exclusively obtained by estimating the relative number of spores present. In isolating *B. welchii* from war wounds, when it was present with *B. coli* and other facultative anaerobes, it was very desirable to induce sporulation so that, by heating, the nonsporing forms could be eliminated. I carried out a series of experiments

growing it in meat with *B. coli* or *B. proteus* with the idea that the antagonism of the *B. coli* might stimulate spore formation which I look upon as a response to relatively unfavorable growing conditions. In many cases I was successful but not in all. The buffer action of the meat particles I believe prevents the activity of excessive acid which in itself interferes with spore formation and the same is undoubtedly true of fecal contents.

What is the importance of the anaerobes in the intestine? That is a difficult question to answer. There is no doubt that they play an important role in certain cases of diarrhea as Kendall, Simonds and others have discussed for *B. welchii*. It would appear that an excessive growth of *B. welchii* may act through its butyric acid production as an excess stimulant to the bowel with a resulting diarrhea. Given food less favorable for fermentation the acid is less and if we also have an increase in meat or other food with buffer action the combination may be helpful in certain cases. I give this only as a suggestive hypothesis. On the other hand we have the putrefactive anaerobes which attack various proteins such as meat, egg, milk clot, cheese and many others, and, with an excessive amount in the diet of meat, for example, we get putrefactive changes. The absorption from the intestines under such circumstances must be decidedly harmful. Passini, however, considers that proteolytic anaerobes actually help in digestion.

With the biochemist studying the products of growth of well identified anaerobes proteolytic, putrefactive and fermentative, with improved technique for isolating these from the intestinal content through the use of media designed to encourage the growth of particular forms such as that used by Tulloch in isolating tetanus bacillus from wounds, in other words, as we gain a more detailed knowledge of many of these intestinal anaerobes we shall be in a position to learn more about their relative frequency and to gain more precise knowledge of their significance. We may hope to expand the excellent work of Herter, Rettger and more especially Kendall along these lines. Wolff and Harris have already made a beginning in the study of war wound anaerobes, but much more work remains with well identified anaerobes of the bowel.

There is one important point to be considered in relation to the anaerobic bacteria of the feces

and that is the wide-spread distribution of these forms. From a bacteriological view the cleansing of the parts after a bowel movement is absurdly inadequate for destroying bacteria and we know that the skin, undergarments and practically all the clothing is richly contaminated with fecal bacteria. The nearer the rectal opening the greater the contamination. The great importance of anaerobic bacteria in infections through the uterus, more especially in abortion cases, is universally recognized and is clearly due to this direct type of contamination. Much has been written and more discussed of gas gangrene in war wounds and it becomes continually clearer that the soldier's clothing soiled with his own feces is probably the most important source of the bacteria involved. The vast majority of serious cases is in wounds of the thigh and lower limbs and the presence of pieces of clothing in the depths of the wounds which act as the foci from which the infection becomes established is an extremely common finding. The conditions in the trenches and the toilet facilities make these views all the more probable. Soil contamination, of course, cannot be ruled out and is of very great moment in conveying the numerous anaerobes of animal feces to the wounds, more especially tetanus spores, but I question its being as important in determining human infection as the means I have indicated.

Anaerobic infection in the abdominal organs is not uncommon. Norman Harris was the first to isolate an anaerobe, *B. mortiferus*, from an abscess of the liver, *B. welchii* and others are common in peritonitis. From the pancreas I have grown *B. bifidus* a high acid forming anaerobe and a rather unusual finding realizing the alkaline secretion of this organ. The appendix adds a long list. In the vagina, anaerobes are frequent but are looked upon as being normally saprophytic which is of course true for many of the anaerobes I am to consider under war wounds. The urethra has been found to harbor *B. welchii*, vibron septique, and many others.

I may now turn from this recital of anaerobes in various regions and infections where their importance is frequently doubtful, to say the least, and devote the remaining time at my disposal to considering the bacteria of war wounds and similar injuries in which no one questions the outstanding and predominant importance of the anaerobic bacteria to man. Weinberg and

Seguin in the Pasteur Institute, Paris; Miss Robertson in the Lister Institute, London; Henry and McIntosh at Base Laboratories, and several others, have all done a great deal to clarify a very confused subject.

It is generally conceded that the anaerobic bacteria met with in war wounds are largely saprophytic. Even *B. tetani*, *B. welchii*, and *vibrio septique*, which are responsible for numerous deaths and most terrible destruction of human tissue, are, anomalous as it may seem, saprophytic types of organisms. They have not the invasive power against healthy tissue that our more pathogenic bacteria have and they require conditions which are nicely adjusted to their needs before they can develop and do harm. This might be said of many well accepted pathogenes but the necessary conditions for these anaerobes are remarkably uncommon and, considering their wide distribution, it is, indeed, relatively rare in ordinary injuries for them to exert their harmful actions. It is taken as a working hypothesis, for example, that *B. tetani* is present in all but the most superficial wounds and nevertheless in the early months of the war when the supply of antitetanic serum was hopelessly inadequate the percentage number of wounded developing tetanus was surprisingly low. At the Ambulance de l'Océan of 800 wounded cases in this period there were six of tetanus or 7.5 per 1,000. And the English in September, 1914, reported about 16 per 1,000 wounded. In October there were 32 per 1,000, but they were at this time in what is called a "tetaniferous" region.

The reason why we had so much serious anaerobic infection in this war is to be found in the nature of the wounds along with the terrible living conditions in the trenches. Without going into the mechanism of the injury produced by the bullet of the modern short range rifle which instead of perforating the tissues point on, tends, on meeting an obstruction, to turn sideways and tears its way through like a dum dum bullet, nor to do more than mention the destructive action of bombs, shrapnel and high explosive shells, we may say that the character of the wounds in this war was different from that formerly met with in that we had more destroyed and devitalized muscle, pieces of clothing, skin and other foreign contaminated objects buried deep in the wounds and that shattered particles of bone were carried by the force of the missiles into still deeper parts.

Every war wound is contaminated, most of them become infected with the establishment of the bacteria, and a very great many show evidence of the presence of growing anaerobes. We cannot imagine a more favorable soil for the growth of numerous types of bacteria than the wounds I have described. Dead, devascularized, devitalized tissue, blood clot and serum enclosed in a cavity at a favorable temperature give ideal conditions for bacterial growth. Multiplication takes place rapidly and time is the most important element in the treatment of this early stage. Henry has reported clinical evidence of gas in a patient four to six hours after injury. The period between the contamination and the establishment of infection may, as this shows, be extremely short.

The stages of anaerobic infection have been divided into four phases. First we find the saccharolytic or stage of sugar fermentation where the active fermenting forms predominate. The *B. welchii* is the most important of these, the *vibrio septique* and *B. oedematiens* coming next in frequency. The second phase blending with the first is that in which the proteolytic group appear and become abundant. *B. sporogenes*, *B. histolyticus* and others appear here and the character of the wound changes. It becomes dirtier in appearance and frequently very foul smelling. A third phase of toxemia and a fourth of blood stream invasion may follow. In favorable cases a bacterial balance is struck, alkali producers neutralize the excess acid of the fermenting forms and the proteolytic types play an important role.

B. tetani may develop in the period between the first and second phases. Tulloch has demonstrated that the growth of *B. welchii* and *vibrio septique* favors the toxic action of the tetanus bacillus and that spores of the *B. tetani* injected in animals would frequently fail to produce tetanus unless cultures of *B. welchii* or *vibrio septique* were also injected. The action of these latter he could control by use of their respective antiscrum. Francis in 1914 showed that *staphylococcus* reactivates latent tetanus spores in animals and quinine has the same effect as was shown ten years before by Vincent. On the other hand Tulloch had demonstrated that filtered meat medium which had been previously treated with trypsin or in which *B. sporogenes* had been grown favored the development of the tetanus

bacillus as well as an oval end spore bearer called *B. tertius*. The isolation of *B. tetani* from wounds is extremely difficult and if we depend for treatment or diagnosis on actually finding the organism it would be hopeless. Harde, for example, only found *B. tetani* once in ninety non-tetanic cases. Tulloch found it in about forty of sixty-four cases of tetanus in a special research. But the vast majority of bacteriologists never even attempt to isolate it. Tulloch believes that the conditions favoring the growth of *B. tertius* and *B. tetani* are the same and that the finding of the former in a wound would indicate that the latter is probably present. The *B. tertius* is rather easily grown.

These phases in the infection and the interrelation of the anaerobes to each other are important for consideration in the study of war wounds. The sparing action of carbohydrate fermenters on the proteins present as shown by Kendall and others finds application here. The muscle tissue dead and devitalized makes a medium containing about 1 per cent. sugar (dextrose and isomaltose) and is therefore very readily fermented by bacteria. The acids produced have, I believe, a very detrimental effect on the surrounding undamaged tissues quite independent of any specific toxins which may be formed. This is indicated by the success of alkaline dressing solutions in treatment. Contaminations of pleural, joint and similar cavities with *B. welchii* and other anaerobes are in the vast majority of cases apparently quite harmless since the carbohydrate content is too low for these anaerobes to establish themselves.

The reaction to anaerobic infection produces, as characteristic, a very marked edema and this interferes with the circulation and completes a vicious circle, as a result of which the growth and spread of the bacteria continues and the condition grows worse. Gas may also produce similar trouble. The success of early surgical interference is due to relieving the pressure of this edema or occasionally of the gas and not to the aerobic conditions which were supposed to be induced. It is quite impossible to render these wounds sufficiently aerobic so that anaerobes cannot grow. The oxygen injection into the infected areas to make them aerobic has also failed in its purpose for the same reason. The elevation and loose bandaging used with the Balkan splint

is extremely helpful in encouraging circulation and lessening edema.

The treatment which has met with the greatest success has been the use of Dakin's solution by the Carrel method. The chief factor in this method is the dissolving action of the hypochlorite solution on the dead tissue, slough and clots, which are then carried out by the flow of secretions and the periodic flushing. The bacteria are largely removed by the mechanical action and what remain, are literally starved to death. This method, preceded by the surgeon removing as completely as possible all dead and nonreactive muscle deprives the anaerobes, as well as other bacteria, of the food material for their growth. The anaerobes are unable to thrive on the living and undamaged muscle which indicates their essential saprophytic character. Dakin has also shown that, with the combination of the hypochlorous acid with the proteins of the serum, the alkalinity of the fluid is increased which helps to neutralize excess of acid which is so frequently found in such wounds. Not only is Dakin's solution effective in the above ways but it is also active in destroying toxins as Dean has shown for *B. dysenteriae* and Austin and Taylor for *B. welchii*.

A more interesting method of treatment is that called by its originator, Donaldson, the biological method and it depends upon the implanting into the wound of the living spores or cultures of bacteria. It recalls Metchnikoff's use of the *B. bulgaricus* in intestinal conditions but goes much further. It has not been established for example that actual implantation of the lactic acid bacilli into the bowel contents has ever been brought about and the effectiveness would appear to have been due to the acid content of the artificial buttermilk so often used as the vehicle. In Donaldson's method there is no doubt that implantation occurs and it is soon made evident to the surgeon, nurses and the entire ward since the wound gives off the foul odor of the organism used. This organism is one frequently, almost universally, found in the second phase of wound infection and, as Weinberg and Seguin have shown experimentally, it is the commonest cause of the putrefactive odor in gas gangrene cases. Donaldson called it the Reading bacillus from the town in which the hospital was situated but he recognized it as a close relative, if not iden-

tical, to the *B. sporogenes* of Metchnikoff. It was noted, under the salt pack method of treatment, that as a rule, the foul smelling wounds did better than the sweet smelling ones. From these former wounds the above anaerobe could always be isolated and it was not present in the other wounds which were not doing so well. After exhaustive experiments which showed it to be non-pathogenic he took the bull by the horns and sprayed living cultures into the sweet smelling slow healing wounds. In a few days they became foul and healing was rapid and uneventful. The *B. sporogenes* is an active proteolytic anaerobe rapidly digesting meat, coagulated egg white and other proteins and is not pathogenic. The organism known as the bacillus of malignant edema is probably the same but the workers with this anaerobe were dealing, it would appear, with a mixture containing a pathogenic type probably vibriion septique. The small colonies of this latter organism would account for its being missed among the tangled woolly growths of the *B. sporogenes*. The success of the treatment with this anaerobe depends on its proteolytic activity as it rapidly liquefies all kinds of solid protein but will not attack living tissue. Moreover, the products of this digestive activity have been shown to be harmless. It is considered more effective in thus cleaning up a wound than even Dakin's solution since it rapidly finds its way into every niche and corner where food material is available. An additional factor of cardinal importance is its destructive action on toxins. Experiments carried out by the author show it to be active in destroying tetanus and diphtheria toxins. There is no evidence that it exerts any antagonistic action on the growth of other bacteria. It is of interest that for many years two of our surgeons in Pittsburgh were in the habit of bandaging up their compound fracture cases and as they said "letting them rot" much to the disgust of the rest of the ward and the theoretical feelings of many. These wounds were extremely foul smelling and when the dressings were removed after long periods they showed healthy granulation tissue and went on rapidly to complete healing. Looking back to these cases, I have now no doubt that they were naturally infected with *B. sporogenes*. The *B. sporogenes* is able to attack carbohydrates but when these

are exhausted it forms alkalies and thus we find the additional value of alkaline production in neutralizing irritating or harmful acids. The proteolytic ferment produced by *B. sporogenes* is closely akin to trypsin which acts best in a decidedly alkaline medium. This is seen in litmus milk cultures of this anaerobe.

The frequent recovery of pieces of clothing from the depths of wounds at operation and the overwhelming evidence that these act as foci for the continued growth of bacteria led to investigation on the possibility of treating uniforms and other clothing in order to make them antiseptic. Miss Davies after trying a number of solutions found that 1 per cent. pyxol, a lysol soap mixture, rendered clothing so antiseptic that after leaving the treated cloth for weeks in the rain and sun it still retained its quality. Experiments in animals showed that such treated cloth heavily contaminated with bacteria and planted in the muscles of guinea pigs only acted as a foreign body and was soon surrounded by fibrous tissue while the untreated cloth similarly contaminated gave rise to abscesses and frequently a general fatal infection. This inhibitory action of the treated cloth was also shown in solid media. Unfortunately this work was not continued and has only been given a very meagre trial under practical war conditions.

The epidemic of injury, as one writer called the war, has taught us much of the importance of anaerobic bacteria and in civil life many of the lessons will find ready application. I have had some experience in the gas gangrene following coal mine injuries and after my study in France working on the war wound infections I have come to the conclusion that fundamentally they are practically the same in character.

(To be Continued)

Dr. J. J. Vizgird of St. Louis was arrested by the Department of Registration and Education for practicing medicine in Illinois without a license. Vizgird was unable to give bond and is now in jail awaiting trial. This is the third time Vizgird has been in the court in St. Clair County for practicing in Illinois without a license. The first conviction was for eight hundred dollars. Vizgird paid this and promised to remain on the Missouri side of the river. He saw a chance to make some money over in Illinois, but he ran into the arms of an inspector who landed him in jail.

TWILIGHT SLEEP: (ITS PRESENT STATUS).

BLAINE L. RAMSAY, M. D.,
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In discussing this subject I will forego the usual preliminaries of its discovery and statistics which to my mind in this subject especially are of very little real value and I might add are more or less confusing. I shall give briefly what to my mind will be of practical interest or guide to the general practitioner.

In speaking of the so-called twilight sleep, one of the anesthetics used by some in labor, we immediately are taken issue with by the anti-twilight sleep school, at the same time being supported by the pro-twilight sleep school. This subject, as all medical subjects, has been successful in certain hands, likewise has it been a failure in certain hands. This gives free reign to individuality,—you can quote statistics either for or against. Apparently our best authorities are fairly equally divided as to its uses, but all are of one mind as to the possibility of danger, although very slight to the fetus.

WHAT IS TWILIGHT SLEEP?

The different nomenclature has been rather confusing, so that until recently* twilight sleep has been rather mysterious to a great number of medical men. As we become more acquainted it simmers down to our well known drugs, namely: morphin sulphate and hyoscine hydrobromide. Hyosine has been camouflaged as scopalamine (the Monnite solution of this preparation seems less likely to deteriorate). The narcophin (morphin-narcotin-meconate) has been employed and is claimed by some to be less toxic than the morphin sulphate. This, however, has not been satisfactorily proven.

THE PURPOSE OF TWILIGHT SLEEP

The purpose of twilight sleep is to produce analgesia plus amnesia which is an ideal condition, but it is not always possible to attain this happy state.

Right here is where good judgment must be exercised and bear in mind that to get a perfect analgesia, plus amnesia, in all cases might be attended by grave risks to the fetus,—therefore, your judgment must in the individual case tell you whether to seek the ideal state or to be

satisfied with a lesser degree of anesthesia. This should be determined by susceptibility of the individual to the drug, condition of the fetal heart and the disposition of the patient to bear pain.

Dosage: The most generally and successfully employed combinations are as follows:

1. Morphin grains 0.25; hyoscine hydrobromide grains 0.01; atrophine sulphate grains one-one hundredth fiftieth.

2. Morphin sulphate grains 1/6; hyoscine hydrobromide grains 0.01; atropine sulphate grains 1-1/180.

3. Morphin sulphate grains 0.25; hyoscine hydrobromide grains 0.01.

Personally I prefer and use the No. 2.

Administration: Always administer subcutaneously and the hyoscine never in smaller doses than 0.01 grain, as great thirst is produced by smaller doses.

The morphin is not repeated after the first injection on account of toxic effect upon the fetus.

Indications: The indications are: 1. Nervous women. 2. Cardiac lesions. 3. Slow and excessively painful dilation of cervix.

Time of Administration: The first dose choosing from the three foregoing doses should be administered when there is great pain, providing dilatation is of two fingers or more so that manual dilatation and forceps delivery can be resorted to if occasion arises. As soon as the effect of the first dose begins to wear off, the second dose consisting of hyoscine hydrobromide, grains 0.01, should be administered, following a careful examination of the fetal heart as to its regularity and strength compared to its pre-twilight status.

Effects on the Fetus: There seems to be little doubt that there is some risk incurred to the fetus. This necessitates careful watching. Frequent auscultation with prompt application of forceps when indicated.

Effects upon the Mother: Following delivery, the patient falls into a refreshing sleep. Pain is forgotten.

There seems to be no effect upon the postpartum contractions,—the danger seems to be entirely to the fetus.

Case Reports: In sixty-five so-called selected cases at the Metropolitan and City Hospital of

New York, we found twilight sleep successful and very beneficial to the patient, although laborious to the physician and nurses. The method employed was similar in detail to those employed today, namely:

Twenty to thirty minutes following first injection the patient was questioned on recent topics and occurrences, was shown objects and a few minutes later the same object would be displayed again,—if the patient did not remember having seen the object we considered our anesthesia sufficient. However, the patient would show facial distortions during uterine contractions and upon being asked directly following such contractions if they had experienced pain, the answer would be in the negative, and as this condition began to wear off we would inject the hyoscine, providing fetal heart tones were good, continuing such line to the termination of labor. We found no excess postpartum hemorrhages, we found no delayed recoveries, we found no interference with milk supply; we did find, however, a great many drowsy babies, especially if delivery was completed within three hours of the first injection, this possibly being due to the effects of the morphin not having worn off. Our method of resuscitation of these babies where excessive drowsiness was present was sphincter dilatation, hot and cold application, warm saline enemas. In some instances the enema containing 1/60 of a grain of caffein-sodium-benzoate, but resuscitation was accomplished with a normal per cent. of failures.

Objections: Some objections might be offered to the lack of abdominal muscle assistance and the inability of the patient to bear down. These factors are, to my mind, unquestionable as to assistance. However, the relief of suffering counterbalances this loss as the labor was materially lengthened in but few cases. Applications of instruments were more frequent, especially low forceps.

CONCLUSIONS:

1. The object of hyoscine-morphin anesthesia is not to bring about complete unconsciousness, but to produce a stupor or sleep from which the patient can be aroused at any time by direct question without recollection of what has passed.

2. That hyoscine-morphin is sufficient in most cases to control pain and is practically safe with ordinary precautions.

3. That ether is not contra-indicated in terminating the labor where the effects are wearing off, or the excessive pain caused by the head passing over the perineum arouses the patient and produces suffering, or where excessive uterine contractions interfere with the delivery of the head.

4. There is danger to the child if the practitioner does not auscultate frequently and carefully the fetal heart.

Individuals differ greatly as to what they hear and in their interpretation of fetal heart tones.

5. That the administration and repetition of injections should be gauged by the amount of pain, the susceptibility of the patient, fetal conditions and not determined by so many minutes or hours intervening since the previous injection.

6. That the so-called picked cases do not run true to form. I do not believe any man can judge accurately beforehand which case is susceptible or not, which case is going to be a long or short labor, which case is going to survive the moulding processes, which uterus is going to fatigue and necessitate interference whether twilight sleep was used or not.

7. That too complete an anesthesia is sought by some, failure to auscultate and interpret properly the fetal heart, and the anxiety to relieve all pain of labor is the source of a great many failures of this method.

8. That lacerations are less frequent, possibly due to the absence of that terrific effort of expulsion to hurry things over.

9. That hyoscine alone causes frequent cases of mania, is not sufficiently substantiated and I advise for such unfortunate cases a careful examination for non-albuminuric nephritis, syphilis, gall bladder and other foci of infection.

The last conclusion which I wish to impress upon you is the fact that I do not recommend this form of labor anesthesia as routine nor do I advocate its promiscuous use, but I do think that if properly applied to highly nervous women or those suffering from organic heart disease, that a great mental as well as physical strain is avoided.

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MODERN CONCEPTION OF IMMUNITY.*

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For years there was adversity among the diverse conceptions of the various theories of immunity. Even yet, this warlike attitude, without modifications, continues. Nevertheless, while maintaining certain variances as to detail, they are at least co-related.

The original advocates of the humoral as against the phagocytic theories of immunity in their struggle for recognition of scientific accuracy claimed superiority one against the other. Though the phagocytic theory assumes the main seat of immunity to be in the white blood cells, the humoral theory of serum action regards the cells of the hemapoietic organs (the mother cells of the white blood corpuscles) as the chief source of the immune bodies, which circulate in the serum.

The humoral theory assumes the premise that the serum, circulating through all organs, is well adapted, as a means of communication to transmit immunity against any infecting organism to all stations, even the outposts.

The phagocytic theory, to be sure, is founded on the premise that phagocytes possess the same property and possessing mobility, while circulating in the serum, they are able to reach all parts of the body to which serum permeates. The working of both theories, in their elemental application, renders them equally indispensable in the overcoming of infectious processes.

Historically the first theories of immunity assumed a humoral direction; notwithstanding this, the science of applied immunity, with the advantage of more knowledge, did not stop at this conception.

In 1887, Fodor found that the blood of rabbits acted destructively upon bacteria and to substantiate this bactericidal powder, he used the plate method. Fisher and Baumgartner immediately raised the objection to Fodor's conclusions contending that with this method (plate method) bacteria were transmitted from serum to culture media and thus a plasmolysis might stimulate a bactericidal action, the former being

due merely to isotonic concentration of the new culture medium.

In 1888, Flügge and Nuttall with their memorable serologic demonstrations on the anthrax and cholera germs gave material for new conceptions. Then came the contributions of the Great Buchner, with his work in determining that a temperature of 55 degrees centigrade was sufficient to destroy the bactericidal power of serums. This was immediately accepted as a fundamental discovery, being the forerunner of Erlich's separation of protective substances of serum into immune bodies (amboceptor) and complement (Buchner's alex theory).

This theory too met with objections from Behring and Nissen, both contending that the destruction of bacteria as observed in the plate method, or under the microscope, did not run parallel with the resistance shown in animals; that for example, animals having a strong bactericidal serum were sensitive to infections and vice versa.

This was the state of affairs when Metchnikoff's phagocytic theory was under the first fire of the divergent yet enthusiastic controversies. There were three very different views of this theory, each reflecting modifications by which the theory was supposed to be reconciled to facts discovered later. The phagocytic theory is considered a cellular theory; however, to regard it as vital in contrast to the humoral theory, in the light of modern research would be incorrect, because both theories are essentially of a vital nature to each other and must be recognized from the viewpoint of immuno-therapy, as co-related concepts in the study and production of immunity.

Viewing the subject of immunity in this light the cellular and humoral theories must be fundamentally regarded as incompatible; for the advocates of the humoral theory do hold that immune bodies and their complements were necessarily secreted by cells.

Bacteria which have invaded the body are not destroyed by their own secretions. If the infection is overcome they must necessarily have been destroyed by the body cells themselves. The field of immunologic research, however, including the various experimental conclusions, differs as to what this destruction of bacteria is due to; leaving this problem still as a question to further

*Read before the St. Clair County Medical Society at East St. Louis, Illinois, February 6, 1919.

investigation, some contending that the bacteria are destroyed by cells and others that they are destroyed by the power of serum. Whatever these diverging opinions may ultimately develop into, from our present knowledge, it is evident that these germ destroying substances are cell secreted.

Some immunologists, in trying to explain the antigenic influences of various devitalized bacterial suspensions on body cells, for constructive ferment production (immune bodies) attempt to classify the respective immunizing substances; contending a differentiation of one form of ferment as against the other and enlarge on the role it plays in the control of infections and the production of immunity. To be sure some claim that the antigenic influence of sensitized bacterial suspensions activate body cells for the production of bacteriotropic and curative antibodies with high phagocytosis, regarding them as the main factors in the production of immunity; while others contend that the nonsensitized polyvalent bacterial suspensions produce large amounts of agglutinins, precipitins, bacteriolysins, plus complement fixation bodies, but fewer bacteriotropins; high agglutination or bactericidal actions cannot be expected from the antigenicity of a sensitized bacterial suspension.

From an academic point of view this study is very significant and constitutes a theoretical importance; however, considering the scientific interpretations of the various phenomena that take place in all processes of immunization, in the light of the knowledge taken from the arsenal of the ferment theories, it is rational to regard the different immunizing substances as different forms of constructive ferments. What particular from of constructive ferment (antibody) is the main vital factor in the prevention and control of bacterial infections cannot be regarded as the important problem in applied immune-therapy.

The main consideration in immunization is to activate body cells for antibody production. This is adequately established when we depend not on one particular form of antibodies, but on all of them, including bacteriotropins, agglutinins, bacteriolysins, complement fixation bodies, etc., regarding them all as forms of constructive ferments secreted by body cells which paralyze, cripple, disintegrate germs and their poisonous products.

The antigenic action of polyvalent bacterial suspensions adequately stimulates and trains body cells for the respective and necessary immune bodies, so as to prevent and overcome infection. We repeat that the establishment of immunity is made possible only by the action of such antigens as are instrumental in the production of all immune bodies in their complex whole.

In conclusion it would not be out of place to say a few words concerning the terminology used in designating certain substances in immunization.

In the problem of infection and immunity, two distinct conditions are involved, the activities of the invading organisms to maintain themselves in the living body and the activities of the living tissues to get rid of the dangerous intruders. In their activities to maintain themselves, germs secrete substances which they employ for the purpose of preparing and assimilating the food on which they live. These substances have a toxic or destructive influence on the body cells (termed toxins). Tissues on the other hand in their defensive capacity, produce substances which have a destructive influence on the invading organisms or their toxins which are usually designated as antitoxins or antibodies. From a closer study of these substances, it is found that some dissolve the germs and for that reason are called lysins; another causes the germs to become sticky and causes them to clump, known as agglutinins. Opsonins make them susceptible to ingestion and destruction by the white corpuscles; precipitins cause them to precipitate and no doubt there are some immunizing substances which possesses destructive influences of a character with which we are not as yet familiar.

Amboceptors are often spoken of as immune bodies in their combination with complement. Aggressins are supposed to be substances which in the presence of infection hasten the activities of the infecting organisms. Aggressivity expresses the force of a micro-organism manifest in maintaining itself in an infection.

Immune amboceptors are also called sensitizers, intermediary bodies, preparation or fixators, etc.

General practitioners who have no opportunity to study the minute details of immunologic science, find it difficult to grasp the thought when

reading articles on immunologic problems from the variety of terms employed applying to essentially the same thing. Much of this confusion is avoided by regarding germ activities and their behavior in infective processes as due to ferments which they secrete or excrete and the defensive activities of living tissues when attacked by invading micro-organisms as due to cell secreted ferments. This constitutes the ferment theory of infection and immunity as worked out by Friedberger, Abderhalden, Vaughan and many others. The soundness of this theory not only accounts for the various phenomena of infective processes and their elimination simplifies the conceptions of the working of the immunizing mechanism as well. We prefer for this reason to use the phrase the "constructive ferments" logically meaning all forms of antibodies or antitoxins, by "destructive ferments" we mean ferments which are secreted or excreted by germs causing infections (toxins).

AN IDEAL ORGANIZATION OF PHYSICIANS.

WARREN JOHNSON, M. D.

CHICAGO.

Several months ago Dr. Ferdinand H. Pirnat, president of the Northwest Branch of the Chicago Medical Society, and I met in my office to discuss ways and means of opposing and preventing the passage of legislative measures which would seriously hinder the progress of medicine, and thereby give rise to a pernicious reaction upon public health. After a lengthy discussion of this problem we decided that the only way to accomplish our purpose would be to bring the physicians together and unite them in a close organization with a bigger and broader purpose than our present medical societies can afford. Dr. Pirnat suggested that a "Physicians' Club," working in harmony with the Chicago Medical Society, the Illinois State and American Medical Association and all classes of society, could be developed into an ideal physicians' organization. At this point we called Dr. J. H. Walsh, chairman of the organization committee of the Northwest Branch, and Dr. A. C. Hammett, secretary of the Irving Park Branch of the Chicago Medical Society, in consultation, and together we worked out the details of the foundation of the "Physicians' Fellowship Club."

The objects of this professional fraternity shall be to enlist the combined strength of all of the doctors in a co-operative effort with all of the civic and social organizations of the city in united opposition to legislation vicious alike to the profession and to the public; to promote a closer co-operation between the doctor, the public and the state; to stimulate an intimate interchange of professional ideas and case experiences; to create, cherish and encourage the spirit of fellowship among all doctors all over the world. We can thus eliminate professional jealousies which might otherwise exist among us, because by interchange of ideas and concepts in social intercourse we would learn that the valuable man in any business is the man who can and will co-operate with other men, and that men succeed only as they utilize the service and ideas of other men.

The fundamental conception animating our organization is the recognition that no individual is independent, no organization of individuals is independent, no nation is independent—we are all interdependent. Biologically, every living thing depends upon some other living thing for its own existence. We, as a profession, well recognize this fundamental fact. Every living thing, in order to live, must live dependently, not independently. Consequently if we wish to obtain the highest degree of perfection in our medical organization, we must co-operate with every other honorable organization.

By following these precepts we would like our neighboring practitioner better; the public would have a more profound respect for all of us, and we would become bigger and better men in the community.

You know that the various medical societies are doing wonderful work in the scientific field of our profession, and we must help and encourage them to continue this good work, but to the individual practitioner who spends most of his time with his patients trying to alleviate their sufferings, the meetings of the medical societies are delinquent in that atmosphere of professional equality and fraternal fellowship which ought to prevail among physicians.

The masterful and individual papers which have been individually prepared and presented to us with the cold and rigid formality that predominates at our meetings rob us of the feeling of liberty to discuss them and compel us to sit and listen to them in silent approval, whether

good or bad, clear or occult. This kind of a paper is very necessary among those of our profession who teach, but the majority of doctors do not teach—we practice—and it is essential that we acquire practical knowledge, and it is to this end that the Physicians' Fellowship Club will strive to be of the greatest service to the practitioner.

The papers that we propose to have in our club will be more of a joint paper, co-operatively prepared and individually discussed by the listeners, with the good in it commonly resolved and digested. The discussions of this kind of a paper will take place around a long table, upon which is something good to eat, and some good cigars. By this arrangement we would have less indeed of the pretentious paper leadership and more of the round table discussion and exchanging of experience, the sum total being a valuable contribution of useful and practical methods, which in time would thus swell to considerable proportions. The trading of "hunches" over smokes or a game of billiards are the sort of hunches which not infrequently, if encouraged and confirmed, lead to real discoveries.

We hope in due time to build a club house conveniently located in the center of the district in which the majority of our members are living and working, where we can run in at any time, night or day, and find a group of sympathizing fellow practitioners with whom we can converse freely about our cases that are worrying us, and by the knowledge gained from a group of this kind we would be better enabled to treat these cases successfully.

At some other time we would meet a group who had a little time to themselves, and we could forget the worries of the strenuous business of practicing medicine and engage in a game of volley ball, hand ball, billiards or some other game that develops both the mind and body, thereby fitting us to do better work in our profession.

These two features alone should be sufficient encouragement for any high-minded physician to support such an organization, because, as physicians, we all know that "all work and no play" creates a vicious circle in the human intellect and undermines the bodily health.

The most practical and logical location for this proposed club house would be in the heart of the greatest medical center in the world, which is on

the west side of Chicago, near the central zone of the city, easily accessible, and provided with rapid transportation facilities to and from all points in the city. Somewhere in the neighborhood of Jackson and Ashland boulevards would meet with these requirements.

Here we are within a few blocks of the greatest teaching institutions, and only ten minutes' ride to the loop. By co-operating with medical colleges, post-graduate schools, and hospitals in this locality, our club house would be an attractive home for medical men from out of town, seeking special or advanced knowledge pertaining to the many departments in the practice of medicine, and would thus be almost self-supporting, and would make it possible for us to accumulate a sinking fund, out of which the incumbrances of the building and ground could be paid off from time to time.

Some of the features of the proposed club house, attractive alike to the medical men at home and the visiting doctors, will be bedrooms to accommodate about two hundred guests, lounging rooms, parlors, billiard room, library, banquet hall, dining rooms, committee rooms, bowling alleys, hand ball courts, shower baths, lobby with a bulletin board of all the clinics scheduled for the day, assembly hall and gymnasium which could be used for dances, and as a meeting place for the many department societies of the Chicago Medical Society, which is the largest city or county medical society in the world, and who knows but perhaps our parent society would do us the honor to meet in our hall?

In this hall we could get together from time to time as friendly adversaries in a game of volley ball, basket ball, indoor base ball, indoor golf, and other games of a like character.

Such a club house would cost between two hundred and fifty and three hundred thousand dollars, but with a membership of three thousand doctors at twenty-five dollars a year each, the "Physicians' Fellowship Club" could easily finance this dream of idealism to an accomplished reality.

The doctors of Kansas City have recently organized a physicians' club and are building the largest and finest club house in that city, which demonstrates to us the fact that by organization, co-operation, and fraternization, the doctors can accomplish anything in reason that they set their minds to do, and if the doctors of Kansas City

can build such a club house, then we ought to be able to build a bigger and better one because of our superior strength in numbers and equal mentality.

The proposed club house of the "Physicians' Fellowship Club," would benefit its members socially, intellectually, physically, and financially. It would share in the effort to elevate humanity, and be a valuable accessory to the Chicago Medical Society, Illinois State Medical Society and American Medical Association, all of which are doing such wonderful work in the scientific field of medicine to enlighten the physician for the benefit of the masses.

As a further step towards the creation of a mutual feeling of professional fellowship among doctors, we propose to have written in our code of ethics, a paragraph to read, That when a fellow of our club gets sick and can not take care of his business, he is to notify the secretary of the club, who will inform the president, and he will appoint a committee of fellow practitioners to take care of the sick fellow's practice, and turn the proceeds from such practice over to the sick member, thereby assuring him of his income, and holding his practice for him when he is sick and not able to take care of it himself. Can you imagine a more ideal, unselfish and desirable state of professional fellowship among physicians? And can you imagine any other organization whose purposes are as efficient to this end as the physicians' fellowship club?

Then there is besides the professional fellowship, another reason why we ought to have a club, and that is the personal fellowship among physicians, and to my mind this is desirable for the sake of fellowship alone, because one can rest better, play better, work better, and sympathize better with those of his own profession and interests, than with those outside of it. The altruistic motive that induced the majority of us to study and practice medicine and the close relationship between the physician and the public, compel us to assume a common trusteeship of the community health, and we can accomplish much by team-play support of governmental efforts for health preservation which are commendable, by team-play pressure for the adoption by the government of such additional health preservation methods as are practical and helpful, and by team-play protest against the tendency of the government to take away from the community

the personal missionary effort of the individual physician, and the substitution for this good Samaritan spirit of an autocratic, unintelligent and impersonal official intermeddling, which but arouses resentment of the public, and hampers the effectiveness of the physician.

Furthermore, our personal knowledge of conditions in the homes of our community, the confidences exchanged between the people of the community and their family doctor relative to their occupations, mode of life, income and habits, together with our professional knowledge, compels us to assume a co-operative trusteeship of the community health for the good and welfare of the community.

We can by co-operation institute legislation for the benefit of the masses by an identification of the physicians in this club as a body with other civic, social, economic and governmental bodies in all propaganda in which the physician's special knowledge, judgment, and skill are particularly useful.

We will co-operate with the city club in its efforts to give the poor people better housing, and improving the sanitary conditions of the workers.

We will co-operate with the school board, with its education of the youth in matters pertaining to sex, eye and contact protection, dietary and sanitary science, and physical examination of children.

We will co-operate with the library board, and city health department, in their popularization of health preservation literature.

We will co-operate with art and literary clubs, and have frequent programs of this sort to enlighten the physician on topics other than the science and art of the practice of medicine.

Yes, we will co-operate, and if necessary to accomplish our purpose, even affiliate with the labor unions, when the labor unions are working for economic improvement of the masses of workers, whether or not those masses are deriving their living by work with hand or brain. We of the brain workers, well can inoculate the labor unions of the country with the bigger and broader vision of usefulness which they can so well accomplish.

We will co-operate with the state legislature, in its will to do well, but that will is so often misdirected because that body having no representative of the medical profession, is unintelligent in medical problems. To it we can bring the professional intelligence requisite to intelligent

action. As a body we can make the legislature see that the physician's motive is that of public service, and not that of public exploitation, that when the physicians as a body oppose a measure, it is not because of a hostile class interest, but rather because we know that such a measure would be working against the physician's holy purpose of showing the public how to get along with the least help possible from the physician.

Other qualities necessary in an ideal organization of physicians such as medical defense, regulation of medical charities, relationship with other societies, local, state and national, regulation of pharmaceutical preparations, ethical relations to members of the profession, and other organizations, raising the standard of professional requirements and attainments, are similarly desirable and commendable and such organizations as the Chicago Medical Society, the Illinois State Medical Society, and the American Medical Association, we would support, we belong to them, and we want them, but as to professional fellowship (versus) professional jealousy, personal fellowship (versus) professional courtesy, a common trusteeship of community health, and a co-operative trusteeship of community health, their present program is inadequate.

Indeed, inadequate through no fault of their own, but through impracticability of their doing more, because their purposes cannot consistently be expanded to include these desirable qualities of an ideal organization, and even if the time comes when they can do so, their equipment, and their budget being so limited makes it impossible for them to do it so well as the "Physicians Fellowship Club," the organization for which I seek your support and registration.

This club can effect professional fellowship, and eliminate professional jealousy.

It can effect personal fellowship, and assume a common and co-operative trusteeship of community health.

It can prevent legislation vicious alike to the profession and the public.

It can assist the legislative committees of the medical societies in amending legislative bills that these bills would be satisfactory alike to the physician and the public.

It can enlighten the members of the legislature on matters pertaining to medical practice, by more intimate co-operation and interchange of

ideas relative to the problem at hand, thereby assuring intelligent action.

It can share in the international effort to elevate humanity.

It can elevate the standard of medical proficiency and efficiency.

It can provide a magnificent club house for the doctors.

It can eliminate the tendency of any individual or group of individuals in our own profession from monopolizing the rights and privileges now enjoyed in all the hospitals by any ethical and conscientious doctor.

Therefore, I request of you for the good and welfare of the profession, the public, and yourself, to lend your support and co-operation by joining the "Physicians Fellowship Club," whose temporary headquarters are in Kedzie Hall on Kedzie avenue, near North avenue, where regular meetings are held every Friday night at nine p. m. sharp, on which occasions a good program is always presented and refreshments served.

Application blanks can be had by addressing the secretary, Dr. Warren Johnson, 3201 West North avenue. The charter membership will close July 1, 1919, and until that time the institution fee is five dollars, and the dues for the first year are five dollars.

3201 West North Avenue.

THE MILITARY TRACT MEDICAL ASSOCIATION.

1866-1908.

R. C. MATHENY, M. D.

GALESBURG, ILL.

The above dates, when referred to the practice of medicine, signify the greatest metamorphosis of thought and scientific achievement that ever took place in any branch of human endeavor. It was the transition from darkness to light. Medicine went through the same mighty revolution of thought that obtained in other spheres of effort. It resembled more the passing away of philosophic reasoning and the induction of scientific investigation. It is illustrated specifically by the lives and work of two individuals, namely, Herbert Spencer and Chas. Darwin. The former devoted his efforts to philosophic reasoning, and the production of his "System of Synthetic Philosophy" was the greatest literary achievement ever accom-

plished by a single individual. And yet today, that work is little more than a literary curiosity. On the other hand, Chas. Darwin devoted his efforts not to prove by philosophic reasoning certain abstract principles, but simply to find out the truth as it related to organic and inorganic matter. His efforts marked the beginning of a new era. Spencerian philosophy faded away and lost its grip on the minds and endeavors of men. Charles Darwin laid the foundations of a system that revolutionized the world's thought. In 1866 the practice of medicine was purely an art. It was the philosophic era of medicine. The ablest physicians of the day thought and reasoned, but how often was thought misdirected and reason misapplied! To them the word etiology simply spelled confusion. The microbic origin of infections and the germ theory of disease were wholly unknown. Yet how they fought and struggled against the concealed enemy!

But between 1866 and 1908 what a dispelling of etiologic darkness. The great Pasteur was at work and, perhaps, to him more than any other, does etiology owe its greatest debt. This is not the place to review the history of medical achievements during the years that intervened between 1866 and 1908. To you who read this article that history is familiar. The writer was the last secretary of the Military Tract Medical Association. Having in his possession the minutes of all the meetings of the Association, he was asked to write this article in reference to it and to some of its members.

The association was organized at Kewanee, Ill., May 22, 1866. The record shows the names of the following physicians as being present: Drs. H. S. Hurd and J. M. Morse of Galesburg; V. C. Seacord, A. C. Babcock, A. D. Babcock, C. M. Clark of Galva; H. Nance, George H. Scott, W. H. Day, J. C. Smiley of Kewanee; N. Holton of Buda; George W. Crossley, S. P. Breed, A. H. Thompson, Charles C. Lattimer of Princeton; S. T. Hume, W. C. Brown of Geneseo; G. H. Vance, Victoria, and E. K. Boardman of Elmira. Originally the only physicians eligible to membership were residents of the counties of Bureau, Henry, Stark, Knox and Warren. When reading the record of the first meeting, almost the first word that strikes you as indicative of the spirit of the times is that the physician should be "orthodox." Orthodoxy! What bitterness, what calumny, what vituperation, even bloodshed has

come because of adherence to its unprincipled principles. In 1866 orthodoxy in medicine played as important a role as it did in religion. But during the forty years of the existence of the Military Tract Medical Association, orthodoxy faded away, and by 1908 it was superseded by the word "legitimate." Orthodoxy in medicine could thrive only during the period of philosophic medicine. It had no place in scientific medicine.

The first officers of the society were:

President—Dr. A. H. Thompson, Princeton.

Vice-President—Dr. H. Nance, Kewanee.

Secretary-Treasurer—Dr. G. H. Scott, Kewanee.

Thus began in 1866 the nucleus of one of the most prosperous and influential medical societies of Illinois. In the first year of its existence we find on the records besides those already mentioned the names of Drs. Ewing, Crawford and J. R. Webster of Monmouth; Drs. Phillips, Hurd and Spaulding of Galesburg. It is interesting to note what a prominent place "Therapeutics" occupies in the papers which were presented during the early years of the society. The meetings were given up almost exclusively to the treatment of disease. One meeting held in 1867 was devoted to the treatment of the itch. A number of the doctors present had served in the Civil war and from the remarks made it appears that the "itch" was a matter of general complaint. It would be impractical to speak of the doctors individually, as their names appear upon the records of the society. But in those early days we notice as taking especially active part in the proceedings the names of Drs. H. S. Hurd of Galesburg, Hiram Nance of Kewanee, Geo. W. Crossley of Princeton, J. R. Webster of Monmouth, and Madison Reece of Abingdon. While these men could not be considered as pioneers in medicine, still they had many of the difficulties of the pioneer to overcome and struggled with heroic courage to combat disease and render what surgical assistance was in their power. One is impressed, in reading the minutes, with the tragedy they endured in their combat with diphtheria. And when we consider the mortality of diphtheria at that time ran as high as 60 to 70 per cent., we readily appreciate the seriousness and often hopelessness of their methods of treatment. This was long before the days of antitoxin, which reduced the mortality of diphtheria to so small a figure. But with what light they had upon the

subject of diphtheria they fought with the courage and self-forgetfulness that equalled any of the pioneers in their early struggle for the advancement of civilization. Surgery in the sixties knew nothing of the modern conception of surgical principles and surgical technique. It was largely mechanical and called for boldness and decision with an admixture of a great deal of common sense. Pus was "laudable" in those days and, of course, the conception of laudable pus would be absolutely antagonistic to the modern ideas of aseptic surgery. Dr. Madison Reece of Abingdon, so far as the records show, was the first man in Knox county to apply extension and counter-extension in the treatment of fractures. Many still remember him as being a man of great force and of unusual ability. Dr. D. R. Webster of Monmouth also was one of the early surgeons of this community and is still remembered by many as one of the rugged, strong characters which impressed themselves upon the community in which they lived. We do not hear much of the seton these days in the treatment of disease or surgical conditions, and yet its use was frequently spoken of and generally with faith in the benefits which were to be obtained from it.

In 1868 Dr. Benjamin Woodward of Galesburg introduced to the society the use of the hypodermic needle and gave a demonstration of its use. Apparently, he was the first to introduce the hypodermic injection of medicines. Medical ethics occupy quite a large place in the thoughts of the old physician and quite frequently we find resolutions introduced condemning the practice of consulting with unorthodox physicians and disapproving of any conduct at variance with medical ethics. As in religion, so in medicine in the earlier days, disbelief in one's own tenets was the paramount sin and it is strange what bitterness and animosity were shown to those who were not within one's own particular fold. Faith was a weightier matter than deeds, and belief surpassed the accomplishment of good. It is rather surprising to see with what complacency and satisfaction some of the earlier surgeons regarded their work, and one case, especially, was reported to the society in 1871 by one of the leading surgeons of the district. The case was his own where he had performed an amputation through the middle third of the arm and it was progressing perfectly satisfactorily, although the wound was still discharging considerable pus fif-

teen weeks after the operation had been performed. As previously remarked, these were the days of "laudable" pus.

The influence of the society was being felt throughout this part of the state and doctors from the adjoining counties began to seek admission. The boundaries were extended to include all of the territory between the Illinois and Mississippi rivers. The society soon grew to have a membership of several hundred. For perhaps the first ten years its policy seemed to have been shaped by the splendid character of the physicians already mentioned. But we also frequently see the names of Drs. E. L. Phillips of Galesburg, M. A. McClelland of Knoxville, and Herbert Judd of Galesburg as appearing upon the records of the society. With the extended territory there were added to the society many physicians throughout the state, whose names have become familiar in Illinois medical history. The scholarly Dr. O. B. Will of Peoria, who for years represented that high type of the medical gentlemen, earnest, intellectual, with a dignified and kindly bearing, which always impressed itself upon any meeting he attended. It would be a great pleasure to speak of the doctors individually as they came into the society, but the list would soon become so extended as to be altogether out of place in an article of this character.

The subjects of medicine, surgery, therapeutics and obstetrics dominated nearly all of the meetings during the earlier years of the society, but about 1870 we notice the subject of ophthalmology mentioned and the reason for that was the entrance to the society of Dr. L. S. Lambert of Galesburg, a man who became the dominating influence in that branch of medicine in this part of the state. Dr. Lambert still carries with him the courtly bearing of former years and the boutonniere is still conspicuous in the lapel of his coat. The benefits to be derived from attending the meetings of the society were sought after by the physicians beyond the confines of its borders. Physicians from Missouri and Iowa are frequently found in attendance. From 1880 to 1890 the society began to feel the effect of the medical awakening, which was being manifested throughout the world and we find bacteriology showing itself in the papers that were read. Many of the older physicians were slow to yield to the newer ideas, but the tremendous truth of microbic infection was being gradually accepted by the med-

ical profession. The society reached its acme of influence about 1890 and for the next ten years exerted a far-reaching influence in medical thought and practice throughout northwestern Illinois. But the reorganization of the American Medical Association, when the County Society was made the unit, affected seriously the Military Tract Medical Association as well as all other district associations. Efforts of the American Medical Association were all put forth toward the development of the county society and only members of the county society had a voice in the state society, which in turn sent its delegates to the National Society. Whether or not it was the double burden imposed by the fees and the time required, the Military Tract Medical Association began to decline. Many of its devoted members did all in their power to hold up the interest and to encourage attendance at its meetings, but the outcome was inevitable and with the growth and prosperity of the county society the district society was doomed to disintegration. From an attendance of several hundred which the society enjoyed for a number of years, it gradually dwindled until at the last meeting held in Peoria in 1908 there was not even a quorum present and enough physicians from that city, who were members of the association, were personally solicited to attend the meeting that business might be attended to. Another cause was, the association was facing financial bankruptcy. It was felt that the meetings should discontinue. At this last meeting the following program was submitted:

PROGRAM.

1. President's Address—S. C. Stremmel, Macomb.
2. The Blood Pressure in Chronic Interstitial Nephritis, With Special Reference to Treatment of the Same—George W. Parker, Peoria.
Discussion led by B. E. LeMaster, Macomb.
3. Ectopic Gestation—E. C. Franing, Galesburg.
4. The Management and Treatment of a Case of Infection by the Bacillus Typhosus—J. P. Roark, Bushnell.
5. Hypernephroma—Dean D. Lewis, Chicago.
6. A Few Practical Points Concerning the Diagnosis and Treatment of Bright's Dis-

ease—J. B. Herrick, Chicago.

7. Brain Tumor. Report of a Case, with Exhibition of Specimens, Both Brain and Tumor—C. B. Horrell, Galesburg.
Discussion led by Peter Bassoe, Chicago.
8. State Management of Tuberculosis—E. T. Jarvis, Macomb.
9. Multiple Sclerosis, with Lantern Slides Illustrating the Lesions—Peter Bassoe, Chicago.
10. Fractures of the Neck of the Femur—M. S. Marcy, Peoria.
11. Surgical Operations on the Neurotic—J. F. Percy, Galesburg.
12. The Practical Results of the Last Meeting of the American Association for the Prevention of Tuberculosis—J. W. Pettit, Ottawa.
13. Chronic Progressive Labyrinthine Deafness—F. K. Sidley, Peoria.

The general character of this program speaks for itself. If such a list of papers failed to attract even a quorum of the association, it was deemed best that it be disbanded. Several of the physicians present expressed their keen regret that such a course seemed necessary. We all realized that the association had served a great purpose. It had exercised a wide and beneficial influence, but its mission was ended. It was time for it to go, and not being human, it was subjected to the kindly act of euthanasia.

BUILDING AND REBUILDING.

JOHN KERCHER, M. D.

CHICAGO.

Formerly Lecturer, Post Graduate Medical School; Formerly Chief of Clinic in Nervous Department, West Side Dispensary; Lecturer and Instructor The Kercher School of Massage and Medical Gymnastics; Formerly in Charge of the Medical Department Clinic, Douglas Hospital; Formerly Lecturer to Obstetric Students and Nurses and Vice-President of Staff of Douglas Hospital; Consulting Physician "The Kercher Baths."

Before our entrance into the present World War, it was generally believed by many people that a large amount of illness of some people was imaginary, for did we not many and many times hear the expression—"She or he doesn't look a bit sick and she or he is always complaining." If the person weighed over 200 pounds, they were considered Hercules of strength. In our recent draft, the public has been awakened with a shock to the fact that had been recognized by the medical profession for a long time—namely, that there are a great many more people with some physical

defect (often serious) than there are people afflicted with imaginary diseases, and the fat men particularly, who were looked upon as physical giants, were all unceremoniously rejected. Why reject physical giants when the country needed and needed badly every "fit" man that could be mustered for our fighting machine, the Army and Navy? There are really three classes into which all people may be divided: the first, those who are well, but who imagine themselves to be sick. They are considerably in the minority. Second, those well or at least without "marked" defects; third, those who imagine themselves "perfectly" healthy, but who in reality are afflicted with various deficiencies, sometimes physical, sometimes mental, often both, and if you were a physician, it would almost make your heart ache to encounter the advanced consumptive who continues to delude himself or herself with the imagination that "this is just a cold." The fat man or woman with flat feet, a little dyspepsia "sometimes," often gouty or rheumatic, manifestations, etc., "unconsciously" shifts the blame for his or her guttous habit (particularly in or past middle age) by stating that "this runs in our family," etc. In civil life, parents and departments of education should make it their business that children should be built right, not only mentally, but physically. Your boys and girls will be the fathers and mothers of future generations. Those people who have some physical defect, should make an effort to get cured. They owe it to, not only their own wellbeing, but to their country, to their wives, husbands and future children, for every child born has the right to be born healthy.

This brings us to an interesting and important topic, namely, "Rebuilding." This should be applied in civil life in all cases where some sickness or defect has changed the vitality, impaired circulation and nutrition, etc. I will especially refer to these matters directly when I take up the subject of rebuilding disabled soldiers and sailors.

In all the many wars this planet has witnessed from ancient history to date, there is none like this, our present World War, that has produced so many marvelously ingenious, new, advanced, modernized appliances, methods, ideas, both *destructive* and *constructive*. I will pass by the *destructive* and concern myself in this writing with the *constructive*, and right here we meet with one of the most ingenious new ideas, the

grand and noble idea of rebuilding and re-educating the disabled soldier and sailor, to make of him again a useful member of society, capable of self-support, and, if possible, capable to care for his loved ones.

During the week of June 10 to 15 there assembled in Chicago one of the largest associations in the United States, and positively the largest body of medical men and women in the world, the American Medical Association. While there were many new and interesting features presented in the various sections in the convention, there were none that elicited so much interest and received so much special space in the press and attracted such a large audience of the profession and the public that the big Auditorium was so overfilled that people were turned away; none, I say, that was the pivot of interest as the newly created section known as the miscellaneous section, "Reclaiming and Re-education of War Cripples."

Chicago may well be proud of the fact that one of its most distinguished physicians was selected by the Surgeon-General of the United States at Washington, D. C., as head of this most important department, Colonel Frank Billings, who also acted as chairman of this meeting. One of the most important facts brought prominently before the public and that struck a responsive chord in the hearts of all true Americans was: In all past wars of all nations, America not excluded, as soon as a man, soldier or sailor, became disabled, he was no longer an asset, but rather an encumbrance, and if he was so fortunate as to reach his home alive, blind, crippled, broken in health, unable to support himself and family at his former occupation, he was allowed to peddle shoestrings or play an accordion on the streets without special license. The special section for reclaiming and re-educating of war cripples was created to give such aid in every way possible to restore these men to become useful, ornamental and self-supporting.

From a program distributed to the audience at this meeting Thursday, June 13, I took the following abstract:

"Great Britain, France, Italy, Belgium and Canada have led in various plans for restoring the disabled soldier and sailor. The experiences of all countries are much the same on certain points, the chief being that the earlier the invalidated combatant, as well as his friends and the

public generally, is assured of his rehabilitation and the sooner it is undertaken, the more successful will be his happy return to civilian life as a contented wage earner. Since the experiences of Canada will probably be most useful to us in dealing with this complex problem, emphasis is laid upon the character and variety of the physical and vocational reconstruction work done in the neighboring dominion."

While surgery, no doubt, will play an important part in the reconstruction for usefulness and cosmetic effect, the most modern ideas in the construction of artificial limbs and adjustment of mechanical appliances contribute its share, re-education in the use of these wood, iron, cork and papier mache adjuncts will do its share in reclaiming the disabled. There is one particular branch of this reclaiming process that I wish to dwell upon, particularly in this writing, as I believe that this particular branch is really the connecting link in the chain of restoration. The connecting link is, that unless you have good nutrition of the defective, the diseased parts, be it an emaciated body or a shattered limb, you can have no healing or recuperation. I think I can make myself more clear upon this subject by reciting briefly the history of one of my patients.

Mrs. X., middle aged, had varicose ulcers on both lower limbs for several years. After all the various kinds of medical treatments, antiseptic washes, salves, powders, etc., the ulcers getting larger, it was considered that she was incurable unless she would submit to an operation (by dissecting out the veins for some distance up the limb, curetting the ulcers and treating the parts like a fresh wound). In reference to the question as to whether primary union would take place then, a question mark was placed after that—? When I took charge of her, I informed her she must remain under my care for a considerable period as I would pay less attention to her ulcers, but would particularly attempt "A Rebuilding" of her entire physique. Give me a healthy body to begin with and I will have no difficulty in directing Nature to heal localized defects.

I began by having all of her teeth drawn; they were badly decayed. I had her gums treated to clean out the pyorrheic pus. I put the patient on astringent antiseptic mouth washes—the beginning of your health is your mouth. Almost immediately her flatulent indigestion stopped, in fact I corrected all the defects of the digestive tract, mouth, stomach and bowels. Then started on iron, arsenic and strychnia tonic; then had a new set of teeth fitted. In the meantime I had the ulcer cleaned often, discontinued salves and other so-called healing substances as soon

as I started treatment, also had her get a *full hot tub bath every other day*, followed by a cold wash off, not with a wash rag, but with a "loofah" to get a color on the skin; also massage treatments were recommended, but she did not receive them regularly on account of inability to get good operators. She was not confined to bed, as is so often recommended in these cases, but rather was informed to keep a memorandum of the number of hours out of every twenty-four she could spend outside and was encouraged to be outdoors.

For over two months no change was noticeable in the ulcers excepting they looked cleaner; in fact not much was done. To give a full and complete history of this case would be tedious for the writer and particularly the reader, but in conclusion let me state that the ulcers were entirely healed up with healthy firm tissue. The patient has passed out of my care; she acts, feels and looks at least ten years younger. While it took somewhat over a year to bring about this result, it should be noted that this patient was apparently incurable. It saved her an operation (she had dreadful horror of the knife) which at best was an uncertainty and the expense of which would have been as much or more as the year's treatment. Furthermore, I am firmly convinced that if I could have had the massage treatments, etc., carried out, she would have recovered in less than half the time.

In many persons where we had a healthy body to begin with—soldiers and sailors—recovery becomes doubtful, slow, indefinite or prolonged. Why? Because through shock (from the injury or shell), hemorrhage, pain, infection, etc., the body becomes weakened, the vitality is lowered, all the vital organs of the body act sluggishly. "Nutrition is at a low ebb." What is to be done? If I were a therapeutic nihilist (one seeking to destroy all medicines), I would say, throw all physic to the dogs and just use massage, Swedish movements, medical gymnastics, fresh air, electricity, baths, electric light, cabinet baths, leucodescent light rays, heat rays, needle baths, douche baths, spinal ablutions, sitz baths, vibratory treatments, etc.; but I will do nothing of the kind. I have studied and used and watched the effect of medicinal remedies and am firmly convinced that if physicians would do a little more studying along those lines instead of prescribing ready-made proprietary remedies they would get better results and we would have fewer medical nihilists, and, above all, there is no fool like the fool who says "I don't believe in medicine." Let him repeat this last sentence after trying a few of these experiments: First, get a piece of emery imbedded in the conjunctiva of your eye; then

let a friend poke around in it (rub it in), then finally have a physician put in a few drops of solution of cocain and extract the foreign body without you knowing it. Second, get a real old-fashioned belly ache, cholera morbus or painters' colic; call in your Christian Science friend, and when you are about ready to have your body and soul break up partnership, get a real doctor—not necessary for me to recite what he does—he does it. Third, in mushroom or ptomain poisoning or poisoning of any kind, give your patient a hypo of $\frac{1}{8}$ grs. apomorphine— $1\frac{1}{2}$ to 3 minutes is all you have to wait, and even a Christian Scientist will "heave to." Fourth, in postpartum uterine inertia, give ergot; if it does not work, the stomach may be coated with mucus, and I believe it often is after childbirth; it may not be absorbed—give it hypodermically, with or without pituitrin. Fifth, as I am taking up too much space in this paper, I would suggest that you take a few teetotalers (concerning medicine) those that do not believe in it, Christian Scientists, and try the following on them:

One each the following hypo nitroglycerin, ammonia, brandy, cocaine, morphin, apomorphinae, strychnia, pilocarpine, atropin, etc. Internally, ipecacuanhae, pulv. mustard, sulph. zinc, antim. et pot. tart., bichloride mercury, iodine, carbolic acid, etc., besides all the vaccines, antitoxines, etc., and last, but not least, don't forget to give your Christian Science friend three to four drops croton oil, then let him repeat the former sentence.

There is, in my estimation, some pronounced kink or rust spot in the brain of the individual who "falls to" when a rhubarb pie is served, but take the same rhubarb and evaporate the water out of it, then put the residual powder in a capsule and, "Oh, no!" They would not take that because that is medicine. Can you beat it?

I have drifted away from my subject just sufficient to show that I am not a one-sided enthusiast or afflicted with the hobby of a physio-medical cure-all. I admit that I am very enthusiastic for the beneficial effects of baths, hot baths, cold baths, douche baths, needle baths, electric baths, electric light cabinet baths, steam baths, massage, Swedish movements, medical gymnastics, light rays, vibratory treatments, etc. Having made special study of these various therapeutic measures, having personally practiced and applied them and having had the opportunity in

years past to write and lecture on the physiological action and proper application of these various measures, places me, I believe, in position to speak with authority of their beneficial effects over and above the average practitioner who is limited to purely medicinal and surgical measures, and I maintain that this is the link in the chain of success for full restoration in the treatment of many ailments, particularly in the restoration and rebuilding of our disabled soldiers and sailors.

TREASURY DEPARTMENT
UNITED STATES
PUBLIC HEALTH SERVICE
WASHINGTON

May 3, 1919.

ARSPHENAMINE

TO THE EDITOR:

It appears that there is a lamentable want of care on the part of many physicians who administer arspenamine as to the concentration of the drug used and the time required for administration.

The Hygienic Laboratory receives many complaints in regard to untoward results from the administration of arspenamine made by various American producers. When careful investigation is made it is almost invariably found that the drug has been used in a solution that is too concentrated, and that it has been administered too rapidly. We have reports of a dose of 0.4 gm. being given in a volume of as little as 25cc. and injected within 30 seconds. Such practice is abuse, not use, of a powerful therapeutic agent.

If, in addition to the usual precautions as to the use of perfect ampules and neutralization, physicians would give the drug in concentration of not more than 0.1 gm. to 30 cc. of fluid and allow a minimum of two minutes for the intravenous injection of each 0.1 gm. of the drug (in 30 cc. of solution) the number of reactions would be very materially reduced. This would necessitate from 90 cc. to 180 cc. of the solution for the doses usually given and would require from six to twelve minutes for the injection.

Any physician who fails to observe these precautions should be considered as directly responsible for serious results that follow the improper use of the drug.

Hoping you may find space in your Journal for this letter, I am

Respectfully yours

G. W. McCoy, Director.

Jeff Mardon of East St. Louis was arrested by an inspector of the Department of Registration and Education of the State of Illinois for practicing medicine without a license. He was fined by the court but was unable to pay it. He was then committed to the county jail for two months.

ILLINOIS MEDICAL JOURNAL

Published monthly by The Illinois State Medical Society, under the direction of the Publication Committee of the Council.

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District 8—Cyrus E. Price, Robinson.
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Send original articles and all communications relating to advertisements and mailing list to Dr. Clyde D. Pence, Editor, 3338 Ogden Avenue.

Membership correspondence to Dr. W. H. Gilmore, Mt. Vernon, Ill.

Society proceedings and news items to Dr. Henry G. Ohls, *Managing Editor*, 927 Lawrence Avenue, Chicago.

Contributors will submit all copy for publication typewritten on standard size paper and double spaced. Copy not complying with this rule will be returned, if convenient.

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State society will pay no bills for legal services except those contracted by the Committee. Notify the Chairman at once. Do not employ attorneys.

JUNE, 1919

Editorial

DR. GRINSTEAD, PRESIDENT-ELECT.

The friends of Dr. W. F. Grinstead, who were not at the Peoria meeting and who have known him so long as one of the active Society men, will be glad to know that he was honored by the Society. Dr. Grinstead knows the needs of the Society as well as any other man, and those who know him also know that he will fulfill the duties of that office and uphold the dignity and honor of the Association.

THE PEORIA MEETING.

Some little disappointment existed at the annual meeting because of the light attendance. The registration number was 600, with perhaps a few who did not register.

The weather "man" treated us poorly. Rain throughout the entire session and temperature too cold for comfort, accounted for many not attending, we think. It is difficult for one's enthusiasm to overcome the personal discomfort of a week's cold, rainy weather.

However badly the elements treated us, the program committees redeemed the day by furnishing an exceptional class of papers and in large numbers. We believe few sessions of the Association have had a better program to offer.

The following officers were elected:

President-Elect, Dr. W. F. Grinstead, Cairo.

First Vice-President, Dr. George F. Weber, Peoria.

Second Vice-President, Dr. Clara Seippel, Chicago.

Secretary, Dr. W. H. Gilmore, Mt. Vernon.

Treasurer, Dr. A. J. Markley, Belvidere.

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Councilor Fifth District, Dr. C. S. Nelson, Springfield.

Councilor Seventh District, Dr. C. F. Burkhardt, Effingham.

Councilor Third District, Dr. J. S., Nagel Chicago; Dr. S. J. McNeill, Chicago.

Delegate to the A. M. A., Dr. J. H. Rice, Quincy.

Delegate to the A. M. A., Dr. M. L. Harris, Chicago.

Alternate to Dr. Rice, Dr. W. C. Blaine, Tuscola.

Alternate to Dr. Harris, Dr. J. H. Walsh, Cook.

Members of the Public Policy Committee—Dr. Mary J. Kearsley, Chicago; Dr. H. N. Rafferty, Robinson; Dr. A. B. Smith, Woodstock.

Members of the Medical Legislation Committee—Dr. Noble M. Eberhart, Chicago; Dr. Edward Bowe, Jacksonville; Dr. Don Deal, Springfield.

Members of the Medico-Legal Committee—Dr. J. R. Ballinger, Chicago; Dr. George Stacy, Jacksonville.

Member of Committee on Medical Education—Dr. G. Henry Mundt, Chicago.

Rockford, Ill., was unanimously selected the meeting place for the next convention of the Society.

FREE VENEREAL CLINICS.

One of our pleasant memories of the Peoria meeting was in making the acquaintance of Dr. Huff, captain in the Federal Public Health Department.

Dr. Huff has taken exception to our criticism of the introduction in Illinois of the free venereal clinic. We still are opposed to the plan as it is being carried out, but we find that Dr. Huff is even more opposed to the free work than we have been. Dr. Huff thinks this work should be done by the profession at large and that none of it should be free, but that any case of infectious or communicable disease should be immediately cared for, and if the individual is unable to pay for the care, the Government should pay, and pay the same fees that a physician charges for his private cases, the clinics being merely for the post-graduate instruction of the physicians.

If this were carried out as Dr. Huff would wish, there would be left but two objectionable features, namely, the reporting of venereal cases and the paternalistic pauperizing effect on the treated patient. As presumably the great majority of those treated would belong to the prostitute class, the objections would be less than in a general dispensary clinic.

Our principal objection has been, and still is, in the continued and persistent efforts of all of our departments of health to practice medicine and not confining their efforts to public health and the prevention of disease.

Dr. Huff says:

I am a physician and I am not ashamed of it, but I am ashamed of the medical profession, when I see them lacking in a due appreciation of their true worth, and accepting the pittance for their services, which an ungrateful public hands them. If our state and our nation are willing to pay our police department, fire department and National Guards for the protection of life, liberty and property, then they should be willing to pay the medical profession for protection against disease.

Every Doctor who cares for infectious or contagious disease is protecting the Public Health, and if the patient is unable to pay him, the state or nation should.

If we can spend billions of dollars to fight an enemy that threatens our life and our liberty, then we should be willing to spend billions to pay the soldiers who

fight disease, the Doctor who is always on the job, night or day, hot or cold, wet or dry, always on the firing line fighting infectious and contagious diseases, never thinking of himself. He is daily as much of a hero as our heroes who went over the top, self sacrificing, serving the poor, furnishing their medicine, oftentimes food and clothing, serving the family with unpaid bills with the same alacrity as those whose bills are promptly paid. A friend, a confidant and comforter, he is the greatest asset that any community can possess. And the medical profession owes it to itself to demand by organization that we receive pay commensurate with our service to the public at large.

It is encouraging to us to at last find a public health officer who is not hammering at the physicians to do free work for the community or to do such work if not free at a greatly reduced charge.

RESOLUTIONS OF THE HOUSE OF DELEGATES.

The following resolutions were recommended by the Resolution Committee and accepted by the House of Delegates of the Illinois State Medical Society in session at Peoria, May 22, 1919:

WHEREAS, the hand of death has removed Doctor Duncan R. McMartin and

WHEREAS, the Illinois State Medical Society thus loses a valued and efficient member and its Medico-Legal Committee a faithful and resourceful advisor, and

WHEREAS, the Community suffers the loss of a gentleman of noble character and a citizen of lofty ideals, therefore be it

Resolved, that the Illinois State Medical Society represented by its House of Delegates, do hereby express its appreciation of the loss which the Society and Community have suffered in the untimely death of Doctor Duncan R. McMartin.

(Signed)

C. BRUCE KING,
HUGH N. MACKECHNIE,
CHAS. E. HUMISTON.

* * *

WHEREAS, the grim reaper has once more entered our ranks and removed from our Society one of our worthy and beloved members and delegate, and

WHEREAS, this Society feels keenly the loss of Dr. George S. Rainey of Salcm, Marion County, Ill., be it

Resolved, that we, the Illinois State Medical Society, have lost a good and faithful member, and be it further

Resolved, that these resolutions be printed in the ILLINOIS MEDICAL JOURNAL and a copy sent to his widow.

* * *

WHEREAS, The House of Delegates at the 1918 meeting passed a resolution endorsing Annual Registration for physicians, and

WHEREAS, mature consideration shows such action to have been ill-advised, therefore be it

Resolved, that the House of Delegates do now rescind said endorsement, and be it further

Resolved, that the entire matter be expunged from our records.

* * *

INTRODUCED BY DR. CHAS. E. HUMISTON

WHEREAS, a great part of the work of caring for the sick and suffering is carried on in hospitals, and

WHEREAS, a very important part of the instruction of a medical course must be given in hospitals, and

WHEREAS, the course of instruction in training schools for nurses takes place almost wholly in hospitals, and

WHEREAS, the standardization of hospitals is thus of vital importance to the public welfare, therefore be it

Resolved, that the President of the Illinois State Medical Society appoint a committee of five members, which committee shall act for and in the name of the Society in this matter of Hospital Standardization.

* * *

RESOLUTION INTRODUCED BY CHAS. J. WHALEN

WHEREAS, the Harrison Law for the control of Narcotic Drugs is really a public health measure and the revenue feature only a legal subterfuge so that Congress could exercise jurisdiction. The tax, therefore, being merely a pretext, should be a minimum and purely a nominal one, and,

WHEREAS, originally the law required physicians who desire to prescribe the drugs covered by the Act to pay an annual registration fee of one dollar, this tax physicians cheerfully paid, accepting it, is another of the numerous burdens placed upon the profession for the sake of the public benefits it was claimed would be derived from the measure. There are 150,000 physicians in the United States. The law, therefore, imposed a tax of \$150,000 on the medical profession for the protection of the public, and,

WHEREAS, the last session of Congress, in the Revenue Law, increased the fees for registration under the law to three dollars which means, that the physicians in the United States will be required during the next year to contribute one half a million dollars purely for the public good and not in any sense for the benefit of the profession, and,

WHEREAS, while the Harrison Law is of no benefit to physicians, but on the contrary it is a source of inconvenience and annoyance. There is not the slightest excuse either legal or social for increasing the fee to three dollars. There is no justification for placing the expense of this public health measure on the doctors then there would be for placing the entire burden for fire and police protection or public school maintenance or even the entire burden of running the state and national governments on the medical profession.

Neither is there the slightest excuse for making the law a revenue raising measure, but if revenue must be raised, inasmuch as the law is supposed to be for the

protection of the public the money needed for carrying out its provisions should be raised by general taxation and not by a special tax on the medical profession.

WHEREAS, according to the Medical Economist of New York (April, 1916) one-fifth of one per cent of the population of that city (the medical profession) does 95 per cent of the charity work, and in Chicago in 1907 an authentic survey showed that 25 per cent of the population received free medical treatment, while the average normal per cent of the population receiving charity other than medical was one-half of one per cent. The accuracy of this was vouched for by the Bureau of Charities and the Committee on Abuse of Medical Charity of the Chicago Medical Society, and,

WHEREAS, the Chicago Bureau of Charities, 1907, is authority for the statement that in this city, having at that time a population of 2,000,000, the total amount of charity expended per year was \$2,500,000. This includes the amount spent by the city, county and private organizations of every name and nature. Contrast this with reliable data presented at the time showing that the little band of physicians then numbering 3,000 were giving annually upwards of \$7,000,000 to charity, or three times as much as all other agencies combined, and,

WHEREAS, the same general condition prevails throughout the world, namely, that an unjust proportion of the responsibility in caring for the poor and unfortunate of the state falls upon the medical profession to a degree out of all equitable proportions. Therefore, it is neither fair nor just to place a revenue raising tax on the medical profession in order to carry out a public health measure, the cost of which should be paid by the general public, therefore be it

Resolved, That the House of Delegates of the Illinois State Medical Society go on record as being in favor of repealing the law and for making the Harrison Narcotic Law registration fee for physicians a minimum one or just sufficient to validate the act, be it further

Resolved, That our delegates to the American Medical Association be instructed to see that this matter is brought up at the next meeting of the Association; that a copy of these resolutions be sent to all the Illinois senators and congressmen and that they be urged to co-operate with the law makers in Washington to bring about this result.

* * *

INTRODUCED BY DR. H. P. BEIRNE

WHEREAS, Indemnity insurance companies insist on an itemized statement for medical and surgical services rendered our clients, and

WHEREAS, the said companies show a tendency to question good faith and reasonable bills rendered by the medical profession, when they are not on the ground nor familiar with the facts or situation, and said criticism is usually made by laymen, and

WHEREAS, it is impossible to itemize professional service and opinion in dealing justly with our clients, be it

Resolved, that itemizing accounts is only a club to discredit our profession and commercialize it, and should be discontinued, and be it further

Resolved, That we take exception to the general tendency and treatment shown us in such cases by indemnity companies in general, and be it further

Resolved, that a copy of this resolution be published in our State Journal.

* * *

INTRODUCED BY DR. H. P. BEIRNE

WHEREAS, the cost of living has increased 75 to 100 per cent the past ten years, and

WHEREAS, the cost of medicines, instruments and everything else used by our profession has increased in proportion to the cost of living, and

WHEREAS, the cost of medical and surgical services has not increased in proportion to the above, be it

Resolved, that the House of Delegates endorses a general increase of fees over fees now in force, to offset the above increase, and be it further

Resolved, that a copy of this resolution be given to the County Secretaries and published in the ILLINOIS MEDICAL JOURNAL.

* * *

Another resolution was presented by Dr. H. P. Beirne and adopted relative to the indiscriminate taking of x-rays without the physician's order. A copy of this resolution was not handed in, consequently we cannot publish it at this date, but will publish it in the July number of the JOURNAL.

COMPULSORY HEALTH INSURANCE BASED ON LIES, IS CHARGE.

New York, May 24.—Charges that campaigns for compulsory health insurance conducted in New York, Ohio and elsewhere, were based on "gross misstatements of facts and elusions," were made today at a meeting of the social insurance department of the National Civic Federation. The session was presided over by Warren S. Stone, grand chief of the International Brotherhood of Locomotive Engineers. Mr. Stone asserted the working people were vehemently opposed to compulsory health insurance. He expressed the belief that it would destroy the initiative of the industrial worker.

Committee on Social or Health Insurance of the Illinois State Medical Society.

ED. H. OCHSNER,
GEORGE APFELBACH,
C. A. HERCULES,
W. F. BURRES,
JOSEPH FAIRHALL,
CHAS. J. WHALEN,
Chairman.

S. V. BALDERSTON,
CLEAVES BENNETT,
E. W. FIEGENBAUM,
W. D. CHAPMAN,
J. R. BALLINGER,
Secretary.

THE CONTROL OF DIPHTHERIA.

Recent publications by the U. S. Public Health Service¹ and the New York Department of Health,^{2,3} point the way to more efficient control of diphtheria. Indeed it is not too much to hope that this scourge of childhood may in time be numbered with yellow fever as a subject of historical interest only.

The importance of this subject can be realized from the lives lost from diphtheria, including croup, in the U. S. registration area in 1916, amounting to 10,367. This gave a rate of 14.5 per 100,000 population. The rate declined from 18.9 in 1911; the average of 29.6 in the period 1901-1905 declined to 22.4 in 1906-1910. Great variations, however, are noted in different states and cities.

In Illinois Dr. John J. McShane,⁴ chief of the division of communicable diseases, state department of public health, estimates the cost of this disease to the people of the state at \$1,156,625, based on the 1527 deaths and ten times as many cases reported in the year ended June 30, 1918. This is a little over 1 per cent. of the loss due to tuberculosis, but is well worth saving from a financial standpoint, to say nothing of the loss of life and suffering caused the victims and their families.

The newer methods that promise so much are, first, the Schick test to determine susceptibility to diphtheria. As developed by Dr. W. H. Park,³ director of the bureau of laboratories, department of health, New York City, the susceptibility of children of different ages to diphtheria is as follows:

Under 3 months.....	15	per cent.
3-6 months.....	30	" "
6 months to 1 year.....	60	" "
1- 2 years.....	70	" "
2- 3 "	60	" "
3- 5 "	40	" "
5-10 "	30	" "
10-20 "	20	" "
Over 20 years.....	15	" "

Second, immunity. Dr. Park reports active immunity lasting at least three years in over 4,000 susceptibles vaccinated with toxin-antitoxin. His further observations are as follows:

"It is absolutely harmless. No reaction de-

¹Public Health Reports, May 16, 1919.

²Monthly Bulletin, March, 1919.

³Weekly Bulletin, March 15, 1919.

⁴Illinois Health News, January, 1919.

velops in infants, while in older children and adults a moderate swelling of the arm may appear and last from one to three days.

"One injection gives immunity to 80 per cent. of those previously susceptible; two injections give immunity to 90 per cent. and three injections to 97 per cent.

"Immunity conferred lasts for at least three years, and probably much longer.

"No diphtheria has occurred in those so far immunized."

Could more be claimed or proven for vaccination against smallpox?

The advice so often given to diagnose and give antitoxin early in diphtheria has never made a universal appeal to the profession, though the responsibility for late diagnosis must be shared by the parents. Will this appeal to place this disease in the limbo of medical curiosities meet a better welcome? What objection can there be to giving infants the benefit of this protection against diphtheria, as well as immunity to smallpox?

RESOLUTIONS PASSED BY THE ILLINOIS STATE DENTAL SOCIETY WITH REFERENCE TO THE REPORT OF ITS COMMITTEE ON LEGISLATION.

PEORIA, ILLINOIS, May 15, 1919.

WHEREAS, The Illinois State Dental Society in annual session assembled, having heard the report of its committee on legislation with particular reference to its efforts to secure the co-operation of the Department of Registration and Education in drafting an adequate new Dental Practice Act, and being satisfied that the Committee on Legislation has stood for those reasonable measures which would assure to the public the best possible dental service by safeguarding the admission of men to practice and by protection against incompetent and illegal practitioners; and

WHEREAS, The Committee on Legislation has reported that the Administration has so interpreted the Civil Administrative Code as to deprive the representatives of the Medical and Dental Professions, acting in the capacity of Examiners, of the Official Status to which the high standing of these professions justly entitles them; and

WHEREAS, said Committee on Legislation has further reported that the Director of the Department of Registration and Education has refused to agree to the appointment of the Committee of Examiners for such tenure of office as would warrant adequate preparation to qualify themselves to render the most efficient service and has refused to agree to other measures considered essential in such a law; and

WHEREAS, The Superintendent of Registration has not shown to the members of the Dental Committee of Examiners the courtesy to which this society feels them entitled as professional men, therefore be it

Resolved, That this society, while recognizing the wonderful advancement in state administration provided by the Civil Administrative Code, expresses its disappointment that the representatives of the Medical and Dental professions are classed simply as state employees with no official status, and be it further

Resolved, That this society expresses its disapproval of the attitude of the Director and of the Superintendent of the Department of Registration and Education toward matters most important to the best interests of the profession, and that it directs that copies of these resolutions be sent to His Excellency Governor Frank O. Lowden, to Director Francis W. Shepardson and Superintendent F. C. Dodds, and that copies be sent to the official bulletins of the Illinois State Medical and Dental Societies for publication.

G. WALTER DITTMAR,
President.

J. P. LUTHRINGER, Secretary.

FIRST BLIND MESSAGE CLASS IN AMERICA

In England, at St. Dunstan's Hotel for the Blind, massage was taught as early as 1915 to blinded soldiers and these men were successful in the work of reconstruction along this line.

Note the following letter sent to Sir Arthur Pearson, founder of St. Dunstan's:

11 Nelson Street, Liverpool,
11th November, 1918.

Director of Military Orthopedics.

My dear Sir Arthur:

The work which your blind masseurs do is very exceptional in quality. They are in every sense of the term a great success. I find them all intelligent and possessed of a wonderful gift of touch together with keen enthusiasm for their work. Apart from their qualities as masseurs, I think they have an extraordinary good psychological effect upon their patients. I consider institutions which secure the services of these men trained at St. Dunstan's very fortunate. I am

Yours very truly,
(Signed) ROBERT JONES
Major-General, I. S. M. S.

In July, 1918, the first blind massage class of America was established in Chicago, under the personal direction of Mr. Peter J. Peel. Through the co-operation of Dr. Jacob Bolotin, the blind heart and lung specialist, the class was carefully picked from a large group of blind people. Six men and two women were selected. To this group Dr. Bolotin lectured on the fundamentals of anatomy and physiology necessary for their future work. Recently Sir Arthur Pearson, of London, has sent for the use of

this class, fifteen books in Revised British Braille, a compilation of the technical knowledge obtained from a digest of the most scientific works written on this subject. The following authors have been drawn on: Ashby, Cuning, Halleburton, Hudson, Palmer, Kurre, W. Ostrom, C. F. Stout and Dr. Justina Wilson.

Technical knowledge thus provided, a class was prepared for Mr. Peel's instruction in the actual operation of massage.

The class has now been graduated and the following article deals with its progress at the present time.

The following subject was presented by Dr. Wm. Pusey and Mr. Peter J. Peel at a meeting of the Chicago Medical Society, held on May 7, 1919:

Dr. Pusey called attention to "The Lighthouse," an Illinois organization for helping the blind people and stated that they had recently made arrangements to have them study massage, and that they had proved particularly adaptable to this work. The work had not been done before in this country, but it seemed to be a very good field for them. He introduced Mr. Peter Peel, who had been instructing classes in massage and who wished to bring the work to the attention of the medical profession.

Mr. Peter Peel said that about eleven months ago he was told something of the deplorable condition of the educated blind in Chicago, and someone had suggested that it might be possible to teach them massage, thus giving them a better chance to make a livelihood. Some of these people, although educated, were making a very poor living, many of them begging or performing more or less menial tasks. He did not see, at first, how they could be successful in the work, and after carefully looking the field over, could find no record of such work having been attempted elsewhere. However, as the situation was desperate, he took a class of ten and the blind physician, Dr. Jacob Bolotin, took up the matter of teaching them anatomy. After eleven months he found that they were extraordinarily good at the work.

He requested the co-operation of the physicians of Chicago in sending them patients, particularly poor patients who could not afford to pay, that they might have an opportunity of going more thoroughly into the work and gaining practical experience. It was his plan to take two of them into his office at a time to serve a sort of internship for a few months, during which time they would be paid \$20 to \$25 a week. More definite detailed information could be obtained by communicating with Mr. Peel at his office, 20 West Jackson Blvd., Har. 8128.

Correspondence

FEDERAL BOARD FOR VOCATIONAL EDUCATION.

DIVISION OF REHABILITATION

DISTRICT VOCATIONAL OFFICE.

May 29, 1919.

To the Editor:

We are pleased to announce that after May 30, 1919, the office of District No. 8, Division of Rehabilitation, Federal Board of Vocational Education, will occupy the eighth floor of the Consumers Building at 220 S. State street, Chicago.

You will be interested to know that at the present time we have placed over three hundred men in training in fifty different institutions in this district. We have secured employment for several hundred others, and have established contact with several thousand men whose cases are being given the careful attention of our district and central offices.

With an augmented staff and the increased facilities of our new quarters we will be able to give real service to the increasing number of our American boys who have been disabled in our Army, Navy or Marine Corps, and who now desire to take advantage of the vocational re-education which the Government through our board has to offer them. Everything possible will be done to reach every man or woman who has earned this training.

We appreciate your efforts to assist us in carrying on the vocational rehabilitation work and wish to assure you that we desire your continued support in a program looking to the welfare of those of our boys who stood the brunt of the war.

Very truly yours,

CHAS. W. SYLVESTER,

District Vocational Officer.

Public Health

INFLUENZA-PNEUMONIA MORTALITY IN ILLINOIS FOR 1918

The Division of Vital Statistics of the State Department of Public Health has just completed the compilation of data on deaths from influenza and pneumonia during the year 1918. Inasmuch as the epidemic had not terminated at the end of the past year, it will be understood that these figures do not represent the total cost in human lives of these two diseases. Even so, the influenza-pneumonia mortality

for the year was 32,324, or approximately eight thousand more than the total mortality from communicable disease during an average year. The total mortality for 1918 was 103,138, so that the influenza and pneumonia mortality amounted to about thirty-one per cent of deaths from all causes.

During 1918 the Division of Communicable Diseases had reported to it a little less than 225,000 cases of influenza, but it is definitely known that these figures do not in any way represent the tremendous prevalence of the disease.

The influenza-pneumonia mortality for the various counties of the state for 1918 were as follows; Adams 288, Alexander 101, Bond 51, Boone 84, Brown 28, Bureau 210, Calhoun 28, Carroll 44, Cass 79, Champaign 283, Christian 201, Clark 67, Clay 65, Clinton 94, Coles 144, Cook not including Chicago 1455, Crawford 74, Cumberland 39, DeKalb 127, DeWitt 28, Douglas 69, DuPage 105, Edgar 98, Edwards 83, Effingham 97, Fayette 64, Ford 65, Franklin 310, Fulton 270, Gallatin 35, Greene 93, Grundy 114, Hamilton 30, Hancock 95, Hardin 46, Henderson 20, Henry 160, Iroquois 124, Jackson 146, Jasper 39, Jefferson 97, Jersey 25, Jo Daviess 57, Johnson 44, Kane 498, Kankakee 260, Kendall 31, Knox 181, Lake 1333, LaSalle 563, Lawrence 68, Lee 87, Livingston 123, Logan 149, Macon 250, Macoupin 204, Madison 554, Marion 168, Marshall 36, Mason 56, Massac 86, McDonough 86, McHenry 80, McLean 248, Menard 49, Mercer 49, Monroe 38, Montgomery 127, Morgan 180, Moultrie 56, Ogle 77, Peoria 594, Perry 105, Piatt 50, Pike 64, Pope 13, Pulaski 90, Putnam 51, Randolph 80, Richland 25, Rock Island 586, Saline 118, Sangamon 511, Schuyder 42, Scott 24, Shelby 89, Stark 19, St. Clair 612, Stephenson 124, Tazewell 181, Union 117, Vermillion 426, Wabash 43, Warren 65, Washington 42, Wayne 105, White 70, Whiteside 118, Will 599, Williamson 209, Winnebago 1660, and Woodford 89.

REPORTED CASES OF LETHARGIC ENCEPHALITIS

The State Department of Public Health up to this time has received reports and has investigated exactly one hundred cases of Lethargic Encephalitis. Several months ago the Department required the reporting of all cases of Lethargic Encephalitis so as to permit thorough investigation of each case and it is believed that, on account of the unusual nature of the disease and the popular interest in it that the reports have been practically complete.

The cases investigated up to this time are distributed in the various counties as follows: Adams 1, Alexander 1, Brown 1, Clark 1, Clinton 1, DeKalb 1, DuPage 1, Edgar 1, Effingham 2, Ford 1, Iroquois 1, Vermilion 1, Johnson 2, Lake 3, LaSalle 1, Logan 3, Macoupin 1, Madison 2, Mason 1, McDonough 1, Menard 1, Ogle 1, Perry 1, Richland 1, Rock Island 1, Sangamon 3.

With this relatively small number of cases in a

state with a population of seven million, it is rather a coincidence that one of its victims was a young woman employed until the outbreak of the war, in the State Department of Public Health.

FINE FOR VIOLATION OF QUARANTINE

In the courts of Montgomery County judgment has just been secured by the state's attorney against Morgan Pierpont of Nokomis for violation of the rules of the State Department of Public Health in relation to smallpox. Maintaining that he did not believe in quarantine to which he was subjected, Pierpont attempted to ignore the rules, with the result he was placed under arrest, prosecuted and subjected to a considerable fine.

STATE AND COUNTY COLLABORATING HEALTH SERVICE

As a means of establishing the closest possible relationship between the State Department of Public Health and the medical profession and of keeping the Department constantly advised of local conditions as well as advising the various communities of the activities and facilities of the Department, there was established some months ago a state and county collaborating health service through which the Department will ultimately be represented in each county in the state.

In the establishment of this service each county medical society is asked to designate one or more of its members who, in the absence of the district health officer and in the existence of emergency, will act for the Department, being compensated on a reasonable per diem basis. From time to time all these representatives will be brought together at a central and convenient point for the purpose of convenience in regard to the more important phases of preventive medicine, particularly of a technical character, with the understanding that they shall report to their county medical societies the results of these conferences, thereby stimulating from the interest of local physicians in those phases of public health activity usually relegated to the health officer. This plan of health conference is regarded as particularly important in view of the fact that many Illinois communities still retain laymen as health officers or employ boards of health in which no physician is charged with the responsibility of health conservation.

Up to this time, forty-seven county medical societies have accepted the invitation of the State Department of Public Health to participate in this collaborating health service. They are represented by the following physicians: Adams County, Dr. A. M. Austin, Mendon; Dr. E. B. Montgomery, Quincy; Boone County, Dr. R. W. McInnes, Belvidere; Dr. A. J. Markley, Belvidere; Carroll County, Dr. J. D. Lyness, Savanna; Christian County, Dr. C. M. Seaton, Morrisonville; Coles County, Dr. R. J. Coultas, Mattoon; Dr. O. W. Ferguson, Mattoon; Crawford County, Dr.

G. H. Henry, Oblong, Dr. J. A. Ikemire, Palestine; DeKalb County, Dr. G. S. Culver, Sandwich, Dr. L. E. Barton, Malta; DeWitt County, Dr. J. M. Wilcox, Clinton, Dr. Geo. S. Edmonson, Clinton; Douglas County, Dr. W. C. Blaine, Tuscola; Edwards County, Dr. R. L. Moter, Albion, Dr. J. L. McCormack, Bone Gap, Dr. H. L. Schaefer, West Salem; Fulton County, Dr. D. S. Ray, Cuba; Gallatin County, Dr. J. A. Womack, Equality; Greene County, Dr. H. W. Chapman, White Hall, Dr. H. W. Smith, Roadhouse; Grundy County, Dr. H. M. Ferguson, Morris; Henry County, Dr. P. J. McDermott, Kewanee, Dr. J. W. Westerlund, Cambridge; Jackson County, Dr. H. H. Roth, Murphysboro; Jefferson County, Dr. Walter Watson, Mt. Vernon, Dr. J. H. Mitchell, Mt. Vernon; Kankakee County, Dr. L. G. Wisner, Herscher; Kendall County, Dr. L. A. Perkins, Yorkville, Dr. R. L. Wall, Yorkville; LaSalle County, Dr. W. W. Greaves, LaSalle, Dr. W. P. Fread, Ottawa; Lawrence County, Dr. F. F. Petty, Lawrenceville; Livingston County, Dr. John Ross, Pontiac; Macon County, Dr. C. Martin Wood, Decatur, Dr. Lynn M. Barnes, Decatur; Madison County, Dr. John H. Siegel, Collinsville, Dr. Geo. W. Wilkinson, Alton; Marion County, Dr. J. S. Schoonover, Salem, Marshall County, Dr. A. E. Peterson, Toluca; Mason County, Dr. F. K. Martin, Havana; Massac County, Dr. A. E. Miller, Metropolis, Dr. J. A. Orr, Metropolis; McHenry County, Dr. A. B. Smith, Woodstock; McLean County, Dr. C. E. Chapin, Bloomington, Dr. O. M. Rhodes, Bloomington; Morgan County, Dr. J. W. Hairgrove, Jacksonville, Dr. A. L. Adams, Jacksonville; Ogle County, Dr. L. M. Griffin, Polo, Dr. W. E. Kittler, Rochelle; Peoria County, Dr. H. M. Bascomb, Peoria, Dr. A. A. Crooks, Peoria; Randolph County, Dr. J. W. Weir, Sparta; Rock Island County, Dr. G. D. Hauberg, Moline, Dr. Joseph DeSilva, Rock Island; Sangamon County, Dr. Don W. Deal, Springfield; Shelby County, Dr. J. C. Westervelt, Shelbyville, Dr. W. F. Hilsabeck, Windsor, Dr. O. Z. Stephens, Stewardson, Dr. H. S. Corley, Tower Hill, Dr. E. D. Kerr, Westervelt, Dr. J. W. Dobson, Moweaqua; Stark County, Dr. W. L. Garrison, Toulon; St. Clair County, Dr. Edward H. Lane, East St. Louis, Dr. J. W. Rendleman, East St. Louis, Dr. E. P. Raab, Belleville; Stephenson County, Dr. B. A. Arnold, Freeport; Union County, Dr. A. J. Lyrly, Jonesboro, Dr. L. D. Keith, Anna; Warren County, Dr. P. B. Conant, Roseville, Dr. Ralph Graham, Monmouth, Dr. R. C. McMillan, Monmouth; Washington County, Dr. Jas. McIlwain, Okawville; Wayne County, Dr. E. E. Roberts, Cisne; Will County, Dr. F. W. Wernere, Joliet; Dr. T. H. Wagner, Joliet; Williamson County, Dr. D. S. Boles, Herrin; Woodford County, Dr. Winfield S. Morrison, Minonk, and Dr. Frank W. Nickel, Eureka.

DECATUR ORGANIZES HEALTH SERVICE

Commissioner of Public Health and Safety, Mattes, announces the reorganization of the health department of the City of Decatur.

Dr. T. H. Neece has been appointed Superintendent of Health and will give his whole time to the duties of his office. It is understood that the salary is \$4,000 per annum.

Mrs. Ruth Sweeney assumes the duties of Superintendent of the Child Welfare Division.

A venereal disease clinic has been organized in connection with the Decatur-Macon County Hospital with Doctors Hildreth, Garber, Morris and Neece in charge.

BLOOMINGTON APPOINTS FULL-TIME HEALTH OFFICER

As the result of a favorable popular vote on the proposition of organizing an efficient health service for the city of Bloomington, the city authorities have appointed Dr. J. M. Furstman, formerly Health Commissioner of La Crosse, Wisconsin, to be Superintendent of Health and have authorized him to proceed with the organization of the desired service. Dr. Furstman will receive a salary of approximately \$4,000 per annum.

Society Proceedings

ADAMS COUNTY

The April meeting at the Elks' club rooms was well attended.

The report of Dr. Fiegenbaum concerning Health Promotion Week was received, and the chair appointed the following committee: Drs. Rice, Caddick, and Brenner. The secretary stated that Dr. H. L. Whipple had told her of the willingness of Dr. Rosenow, of the Mayo Foundation, to present a paper before the society. The dentists would like to make the affair a joint meeting of the dentists and medics. The secretary was instructed to invite Dr. Rosenow to be the guest of the society at some time convenient to him.

Dr. R. E. Shastid, secretary of the Pike County Medical Society, sent an invitation to our members to attend the meeting of the Pike County Medical Society to be held in Pittsfield, April 24. Dr. Francis G. Reder, of St. Louis, read an interesting and practical paper, illustrated with a number of lantern slides on "Vascular Tumors."

The various kinds of vascular tumors were described and the different kinds of injections that had been tried, first alcohol, then paraffin, and finally the successful one, boiling water. The doctor himself has injected 204 tumors. The kind of syringe used was passed among those present and its various necessary points analyzed.

Dr. Knox, who has recently been given the rank of major, gave a splendid talk about his experiences with the army while overseas.

We certainly had a splendid meeting, one well worth while from every standpoint—business, scientific and social.

Before adjourning, Dr. Whitlock moved a rising vote of thanks be given to Drs. Reder and Knox. Seconded and carried unanimously.

Adjourned.

Regular Meeting, May 12, 1919

The Adams County Medical Society met in regular monthly session, Monday evening, May 12, 1919, at the Elks' Club Rooms.

The most important matter brought up for discussion was "Increase in Fees."

The following resolution was introduced and unanimously adopted.

WHEREAS, The cost of living has increased over seventy-five per cent, the past ten years as well as everything used by our profession; and

WHEREAS, Advances have been made for medical and surgical services in different parts of the country with the view to offset this increase. Be it

Resolved, That the Adams County Medical Society adopt and put into force the following increase in fees:

Ordinary day calls, \$3.00 minimum.

Night calls, between 10 p. m. and 7 a. m., \$5.00 minimum.

Calls during epidemics extra.

Office calls, \$1.50 minimum.

Normal labor cases, \$25.00 minimum. Instrumental cases extra.

Consultations, \$10.00 minimum.

Assistants' fees in surgical work, \$10.00 minimum.

Anesthetics, \$10.00 minimum.

Calls outside of city, \$3.00, and \$1.00 per mile.

Calls in country made by members from smaller towns, \$3.00 and \$1.00 per mile.

Fees for general management of medical and surgical cases allowed.

Medical and surgical service not mentioned in this resolution, a general increase of fifty per cent over fee bill now in force, is approved and adopted, as amended to take effect June 1.

Dr. Kirk Shawgo, Quincy, showed a number of radiographs of the chest, illustrating tubercular and emphysematous conditions of the thorax, and also cases of hyperthyroidism. Dr. Shawgo's kindness and trouble were much appreciated, and great interest was shown by the members.

In order to make it possible for more of our outside members to attend meetings, it was decided that from now to November 1 the regular sessions be held in the afternoon instead of the evening. Lunch at 12:00 o'clock, business meeting at 1:00 p. m.

Adjournment was then taken.

ELIZABETH B. BALL,
Secretary.

ALEXANDER COUNTY

At the December, 1918, meeting of the Alexander County Medical Society, the following officers were elected: Dr. R. E. Barrows, president; Dr. Jas. McManus, vice-president; Dr. Jas. S. Johnson, sec-

retary and treasurer; Dr. W. F. Grinstead, delegate to the State Society.

JAS. S. JOHNSON,
Secretary.

COOK COUNTY

CHICAGO MEDICAL SOCIETY.

Regular Meeting, May 7, 1919.

A movie film will be shown illustrating the teaching of mouth hygiene in public school in Bridgeport, Conn. This film illustrates a new development in the Health Problems for School Children. The Chicago Board of Education are at the present time considering the establishment of similar teaching in the Chicago schools.—Arthur D. Black.

Scientific Program.

1. Mouth Foci of Infection; Conditions which contribute to their Chronicity, with tables showing the Incidents of Chronic Infection of the Maxillary Bones in Adults.—Arthur D. Black.
2. Relation of the Teeth to the Eyes.—Cassius D. Wescott.
Discussion—Otto T. Freer.
Wm. G. Reeder.
3. Hypertrophied Anal Papillae.
Synopsis: Pathology, symptoms and treatment.
Case report. Illustrated with Lantern Slides.
—Chas. J. Drueck.

Regular Meeting, May 14, 1919.

1. The World's Great Debt to Vivisection.—Albert H. Burr.
General Discussion.
2. The Disposition of the Sac in Hernia.—Emanuel Friend.
Discussion—E. Wyllys Andrews.
Regular Meeting, May 28, 1919.
1. Clinical Aspects of Renal Infections. Illustrated with Lantern Slides.—Daniel N. Eisendrath.
Discussion—Arthur Dean Bevan.
Gustav Kolischer.
Herman Kretschmer.
John S. Nagel.
Jos. Eisenstaedt.
I. S. Koll.
V. C. David.
2. Clinical Diagnosis of Spinal Cord Tumors.
Lantern Slides—J. Elliott Royer.
General Discussion.

FULTON COUNTY

The Eighty-sixth meeting of the Fulton County Medical Society met in the Chamber of Commerce Room, Canton, May 6, 1919, and was called to order at two o'clock p. m. by President Oren.

Councilor Gillespie informing the meeting that the Nurse Bill in its very objectionable form was expected to come up before the State Legislature on its third reading this afternoon, the secretary was in-

structed to telegraph Senator Jewell and Representative Rice to oppose the bill in its present form.

Coleman and Gray moved that the president and the secretary be hereby empowered to use the name of the society in combating any legislation incompatible with public health. Carried.

Necrologist Stoops reported upon the death of Drs. S. L. Oren, D. D. Talbott and Wm. Newberry.

Dr. Gillespie, counselor of this district, gave an excellent paper on "End Results of Focal Infection," and Dr. Price of Astoria one on "Influenza in Military Camps."

The general discussion following these fine papers resulted in making this meeting one of the best that the society has had for a long time. A unanimous vote of thanks was extended the authors.

Eighteen members were present.

D. S. RAY,
Secretary.

MADISON COUNTY

Our February Meeting.

The Madison County Medical Society met in Granite City on February 7, 1919, with President Dr. Chas. R. Kiser in the chair. Twenty-one members were present.

A letter from J. J. Brenholt, Jr., Chairman Board of Supervisors, asking us to nominate the medical member of the board of directors for the new county tuberculosis sanitarium was read and it was ordered that the president and secretary and a third member to be appointed by the president be a committee with power to act, to select one of our members for the above named position. Dr. R. D. Luster was appointed as the third member of this committee.

Dr. W. H. C. Smith was elected State Delegate for a term of two years and Dr. E. C. Ferguson was named as his alternate. Mrs. E. S. Beatty read her report which was ordered placed on file.

The subject of annual registration of physicians was taken up and Dr. Ferguson moved that we reconsider the vote of our August meeting, which endorsed the proposition. Carried. Drs. Ferguson, W. H. C. Smith and J. W. Scott were appointed as a committee to draft resolutions expressing our extreme opposition to any measure requiring annual registration of physicians in any form. Moved and carried that these resolutions be sent to our representatives in the legislature and to the Medico-Legal Committee.

Dr. Wm. Engelbach, of St. Louis, the guest of our society for the day, then was introduced and gave a most interesting and instructive address on "The Relation of Internal Secretion to Common Diseases." He was given marked attention throughout and upon completion, a vote of thanks was tendered him. Adjourned to meet in Collinsville on the first Friday in March.

Our March Meeting.

The Madison County Medical Society met at Collinsville, on March 7, 1919, with President Dr. Chas. R. Kiser in the chair.

Ten members were present.

On motion of Dr. Siegel, seconded by Dr. Vaught, the annual dues for 1919 of members now in government service are to be paid by our society; also the secretary was instructed to draw upon all members who are delinquent on April first. Carried.

The Committee on Resolutions on annual registration of physicians made the following report which was unanimously adopted:

WHEREAS: A paper advocating the annual registration of physicians was read by the Director of the Department of Registration and Education before our society, last August, at the Alton State Hospital, and received our endorsement before we had any opportunity to study the merits or demerits of the plan, and

WHEREAS: A more mature study of all of its propositions disclosed many very objectionable features, which might result detrimental to the best interests of our profession, be it

Resolved: That we hereby rescind the action taken at our meeting last August and now most emphatically recall our endorsement, and be it further

Resolved: That we as a society express our most violent opposition to any form of annual registration of physicians, believing that the interests of the profession and the public can be fully protected by the prompt and efficient administration of the present Medical Practice Act.

Resolved: That a copy of these resolutions be sent to the Chairman of our Legislative Committee, to the Director of the Department of Registration and Education and to our representatives in the Legislature.

E. C. FERGUSON,
W. H. C. SMITH,
J. W. SCOTT,
Committee.

Dr. Harvey S. McKay, of St. Louis, read a very instructive paper on "Intestinal Obstruction—Diagnosis and Treatment," in appreciation of which the society tendered him a vote of thanks.

Adjourned to meet in Alton on the first Friday in April.

Our April Meeting.

The Madison County Medical Society met in Alton on April 4, 1919, with President Dr. Chas. R. Kiser in the chair. Twenty-two members were present.

Visitors: Dr. H. B. Hemingway, of Springfield, representing the Department of Public Health.

Drs. O. O. Giberson, of Alton and S. C. Vaughn, of Wood River, were elected to membership.

A letter from the Alton Welfare Council asking us to appoint two delegates to a monthly meeting to be held in Alton on April 9, was read and the chair appointed Dr. H. R. Lemen and Dr. G. Taphorn.

By unanimous vote the secretary was instructed to write to our representatives in the legislature to use all honorable methods to defeat the House Bill No. 310.

The following resolution was offered by Dr. Mather Pfeifferberger:

Resolved: "That all members of the Madison County Medical Society, in order to enjoy the benefits and protection of the organization must attend six or more of the regular meetings of said society, annually, or be dropped from the membership of the same."

On motion, action on this resolution was postponed to next regular meeting. On motion of Dr. Siegel, it was ordered to meet in Godfrey in July instead of June this year.

Dr. H. B. Hemingway gave a very interesting address on Public Health, touching on hookworm, malaria, tuberculosis and other communicable diseases. He also spoke on vital statistics emphasizing the necessity of making accurate returns of births and deaths.

Dr. John H. Siegel gave us some of his observations of the papers read and subjects discussed at the annual meeting of Industrial Surgeons at Pittsburgh.

After full discussions a rising vote of thanks was offered the speakers.

McHENRY COUNTY

The following officers were elected at our spring meeting at Kewanee, Thursday, May 1, 1919, for ensuing year: President, W. H. Conser, Cambridge; vice-president, Arthur Parson, Geneseo; secretary and treasurer, P. J. McDermott, Kewanee.

The following program was given: "Medical Gynecology," Dr. E. W. Fischmann, Chicago; "Surgical Gynecology," Dr. Channing W. Barrett, Chicago. The following address was delivered by the retiring president, Dr. H. W. Waterous, of Galva:

Address by the Retiring President, H. W. Waterous

For twenty-two years Henry County maintained a very creditable medical society, hence, in a legal sense, is out of its infancy and into the age of maturity.

Prior to that time, some organizations existed at intervals, and district societies such as the "Military Tract" had been entertained within the county, but the meetings were irregularly held and poorly attended.

To Dr. C. W. Hall more than any one else this society owes its existence. As a representative of the Illinois State Medical Society he devoted much time to its interests, and after several ineffectual efforts at forming a county society, called a meeting at Galva, Feb. 18, 1897, and there formed the "Galva District Medical Society," accepting as members any physicians practicing regular medicine within easy access of the place of meeting.

This included towns along the Burlington between Kewanee and Aledo and along the Rock Island and Peoria between Orion and Wyoming with one or two inland towns.

The first meeting was one long to be remembered

by the thirty physicians in attendance. Both day and evening sessions were held, the morning session being given over to the work of effecting an organization, the afternoon to the scientific part of the program and the evening to a banquet.

Papers were read by Drs. Mackay of Aledo, Stewart of Viola, Hohmann of Kewanee and Warner of La-Fayette. These papers were discussed so thoroughly as to fully consume the time of the afternoon session. Perhaps the paper of most interest was that of Dr. Hohmann upon "Diphtheria and its Treatment with Antitoxin." Dr. Hohmann had but recently returned from Europe and had gained his information from the fountain head, as it were, of the supposed value of antitoxin just then coming into prominence as a remedy, and over which much controversy was taking place.

At the banquet Dr. Cole acted as toastmaster and those who responded to toasts were Drs. Thompson, Hall of Toulon, Vanice and Moore, while L. H. Lowe, then a medical student, responded to that subject.

We all know the result in this last instance; a bud which promised well never blossomed. He laid aside the scalpel for the pen, but held on to the scissors. So far as the writer knows, however, he has always used these instruments in a manner square to the members of the profession to which he once aspired, and, while there could have been no doubt of his success as a physician, it is none the less gratifying to know that he has prospered as a journalist. So here's hoping that the number of subscribers to his paper may ever grow larger and deal with him as he has dealt with us.

After continuing for a number of years, this society, conforming to the plan for reorganization by the state society, merged with the newly organized Henry County Medical Society and its meetings have since been held at Kewanee on the first Thursday of May in each year with such other called meetings as may have seemed advisable.

The saying that "New times demand new measures and new men" finds much truth in its application to the practice of medicine. Of the thirty physicians, who twenty-two years ago started this society upon its way, only two or three are here today and not many more are members of the society. Some have gone into other fields or are absent because of sickness or the infirmities of age, but a greater number have answered the final summons, among whom may be named Drs. Cole, Mannon, Ward, Kirkland, Vanice, Lowry, Thompson, Headland, and Lowe. These men were in most cases representative citizens of the places in which they lived and worked, not only in a professional sense, but in whatever went for the community's advancement. Some of their measures may in this day seem crude, but these men followed the light as best they could, and whatever study

and observation revealed to them they gave without reserve to their co-workers, while in a public way not a few of them served with little or no financial recompense in places of the highest responsibility.

As the personnel of the society has changed, so have changed the manner in which human ailments are treated. Twenty-two years ago the regions of the body now daily invaded by the surgeon were looked upon as areas to remain unmolested except in extreme cases. Even appendicitis was a comparatively newly described condition and its treatment a matter of much difference of opinion. As before intimated, the saying would hold equally true as to the use of antitoxin in diphtheria. While vaccine or serum therapy, except as applied to smallpox and diphtheria, was practically untried, and while progress has been slow along these lines, yet valuable results have been achieved such as the prevention of typhoid fever, to spur the profession on to increased effort and lead one to believe that the future success of medicine lies largely in this direction.

Twenty-two years ago, yellow fever and malaria were among man's most destructive foes. By the discovery of and, in a great measure, the elimination of their causes they are now but little feared, and it is to be hoped that in the near future the extermination of the rat and the house-fly, both conveyors of disease and destroyers of property, will eradicate such infections as they are known to carry.

In spite of the aspersions that have been cast upon it, the regular medical profession remains as the nation's most solid wall of defense and in many instances its court of final appeal.

In a community way it says who may safely mingle with his fellow men. It decides who may come upon or depart from its shores. When great enterprises have been conceived but have failed of execution because of the fatality to the workmen employed upon them, it has remained for the medical man to discover and destroy the cause of these fatalities and thus make possible the completion of the work.

A government may issue a call for troops and military commanders may train and educate them with the greatest skill but the medical man selects those fit for training and has the final say as to who shall go "over the top." From remote times, when wars have been waged on many battlefields, and when pestilences have been abroad in the land, until people have fled from their homes in panic and disorder; when the keeper of the house trembled and the grinders have ceased, because they were few and only mourners were about the streets, then the medical man and nurse, inseparable associates, have remained at their posts of duty until the epidemic has abated or they themselves have been slain by the foes they assailed, true to the work to which their lives had been dedicated, "Faithful Unto Death." No less praiseworthy has been their conduct amid the tragedy of both carnage and disease which so recently enveloped the world and whose dark shadows are still upon it. If such are some of the examples of the

authority and deeds of our profession, surely they are worthy of being perpetuated.

Twenty-two years ago, in responding to a toast, one of the speakers said, "United we present a common front to the enemy." True as the saying was then, it seems to have become increasingly so with the succeeding years. Never before have Combination and Unionism occupied such prominent places in our economic life. Never before were so many "isms" and "pathys" contending with us for recognition in the field of medicine and, regardless of the fallacy of their principles, have, through the shrewdness of their founders and a capricious public, attained a prominence to which they are in no wise entitled. This is not to be wondered at, however, for the human body is a mysterious and complex structure, about which the average individual knows but little, so is ready to grasp at almost anything that promises relief from his real or imaginary distress. But falsehood of itself cannot stand. So these cults will feed upon what little truth they possess until, under searchlight of a better informed public opinion, they will wither like a parasitic plant and join the wreckage of similar pretenses that lines the track of the past.

To repeat, those who started this society upon its way have wholly or for the most part seen the procession of life go by. Each year may see the responsibilities of the society falling upon new shoulders. If today an admonition were to come from these pioneers to us, I am sure it would be for more thorough organization, more members, and better attended meetings, thereby assuring to Henry County a medical society commensurate with her other enterprises.

PERRY COUNTY

Perry County Medical Society met in Duquoin, April 10, 1919. Dr. J. T. Leigh, president-elect, declined to serve and Dr. J. D. Byrne of Duquoin was elected to fill the vacancy.

Mr. H. B. Hemenway of the State Department of Health was present and gave interesting and instructive talks on Malaria, Hookworm and Trachoma.

In the discussion of trachoma, Dr. Geo. F. Mead, member of the Perry County Local Draft Board, stated that in their examinations for the service, men with trachoma were found doing Government and all kinds of public work.

A free discussion developed the fact that trachoma is much more common than a contagious disease should be.

Doctors F. B. Hiller, D. O. Mead and J. D. Byrne, who have been in the service, have returned to their practice. Doctor T. B. Kelley of Duquoin, the only Perry County M. D. to cross the water, is still over there. Doctor J. S. Cleland, formerly of Swanwick, who was also in the service, has since been discharged, located in Chicago.

J. S. TEMPLETON,
Secretary.

ST. CLAIR COUNTY

The St. Clair County Medical Society met in regular session at 8:00 p. m., May 1, 1919, with the following officers and seventeen members present: Walter Wilhelm, president; C. W. Lillie, secretary; A. E. Hansing, treasurer.

The president suggested that a revision of the constitution and by-laws of the society be made, but on motion of Dr. Trippel the appointment of a committee on by-laws was postponed until after the State Society meeting.

Dr. C. A. W. Zimmermann read his paper on "Strongyloides Stercoralis."—Report of a Case Showing Same in Feces and Stomach Contents. This paper is a classic and as soon as it can be released for publication will be sent to the Journals. It was discussed by Drs. Henry, Trippel, Spannagel, Campbell, Rendleman and Lillie. The whole trend of discussion was rather seeking more information, the rarity of the case being such that none could add to the information contained in the paper.

Some discussion on the extreme tendency of the public to use aspirin was indulged in, the consensus of opinion being that much harm may be done by its indiscriminate use by the laity.

Dr. R. L. Campbell, chairman of the Public Policy Committee, reported for his committee, but no definite proposals were ready for action.

Society adjourned to meet June 5.

C. W. LILLIE,
Secretary.

SHELBY COUNTY

At the recent Victory meeting of the Shelby County Medical Society, Dr. E. D. Kerr of Westervelt was re-elected president, Dr. W. G. Turney of Cowden vice-president and Dr. Roy W. Johnson of Shelbyville, secretary-treasurer for the current year. Dr. C. F. Burkhardt of Effingham, Councilor of the seventh district, was present and gave a very interesting and instructive address on the subject of some of the bills and amendments that were before the State legislature at that time. It was the opinion of the society that some of these were ruinous to the profession and the secretary was instructed to draw up resolutions in regard to certain proposed legislation which the society felt was harmful to the practitioners of the state who had conformed to the rules of medical education and registration as they are at present and to obtain the signatures of the Shelby County physicians upon the same and present copies to the several committees in the State Senate and House of Representatives, which had such bills in charge, protesting against such legislation.

During the recent epidemic of influenza when the county's quota of physicians were in the army and the men at home were overworked, it was found that the osteopaths and faith healers got in some licks which they had lain in wait for, for a long time.

When their patients would get in critical condition a physician would be called usually to sign the death certificate. Resolutions were passed and a motion carried, "That it be the sense of this, the Shelby County Medical Society, that its members have no medical associations, relations or consultations with any osteopath, chiropractor, Christian scientist, faith healer or any other cult or -ism of like nature in the care and treatment of disease."

Dr. Roy W. Johnson was elected a delegate to attend the State meeting to be held in Peoria; Dr. E. D. Kerr of Westervelt elected alternate.

ROY W. JOHNSON,
Secretary-Treasurer.

Personals

Dr. C. W. Lillie has been made Health Commissioner of East St. Louis.

Dr. Harry S. Gradle has resumed civil practice at 22 East Washington street, Chicago.

Dr. Selim McArthur returned from overseas last month and is stationed at Fort Sheridan.

Dr. Nathan Smith Davis and family are spending the season in Santa Barbara.

Lieut. Col. F. A. Besley gave an address in Kewanee during Health Promotion Week.

Dr. Arthur F. Byfield has resumed his practice at 720 Monroe building, Chicago, limited to internal medicine.

Dr. C. F. Baccus, after overseas duty, has resumed practice in McHenry.

Dr. and Mrs. W. E. Hillyer have removed from Augusta to Boulder, Colo.

Dr. Frank J. Norton has gone overseas for duty with the Y. M. C. A.

Dr. Elizabeth Ball gave an address on Social Hygiene before the Women's Forum at Quincy, May 9.

Dr. John L. Tombaugh of Odell has been designated grand lecturer by the grand lodge of Ancient, Free and Accepted Masons of Illinois.

Dr. Emil Z. Levitin, chief of the neuro-psychiatric board at Camp Funston, has returned to civil practice in Peoria.

Daniel W. Rogers, Lieut-Col., M. C., U. S. Army, has returned from Europe with the Thirty-third Division.

Charles H. Parkes, Captain, M. C., U. S.

Army, was promoted to Major, May 2, while on duty overseas.

Dr. Walter D. Stevenson, after a varied experience in the service, has returned to civil practice in Quincy.

William H. G. Logan, Col., M. C., U. S. Army, has returned from an inspection tour of European military hospitals.

Ernest E. Irons, Lieut.-Col., M. C., U. S. Army, has returned from service and resumed practice in Chicago.

Robert L. Morris, Major, M. C., Illinois N. G., Decatur, has been placed in charge of the Medical Corps organized at Danville.

Dr. Haim I. Davis, Major, American Red Cross, has returned after two months' study of the situation in Poland and Galicia.

Dr. Sidney H. Easton, after two years' service in the Medical Corps, has returned to practice in Peoria.

Dr. Charles Hubart Lovewell resumed practice in Chicago last month after nearly two years' service.

Dr. C. H. Diehl has been appointed District Health Officer for the Southern Illinois District, with headquarters at Effingham.

Dr. Philip H. Kreuscher announces the removal of his office from 2526 Calumet avenue to 30 North Michigan boulevard, Chicago.

Dr. David O'Shea has moved from 4231 Kenmore avenue to the Edgewater Beach Hotel, Chicago.

Dr. John E. Zarembo, Chicago, was exonerated of blame at an inquest over the sudden death of a woman in his office recently.

Dr. Lawrence J. Hughes, Captain, M. C., U. S. Army, has returned to Elgin, and is associated in practice with Drs. Pelton and Gabby.

Dr. O. W. McMichael, recently medical director of the Winyah Sanatorium, Asheville, N. C., has resumed practice in Chicago, limited to tuberculosis.

Dr. Albert A. Lowenthal has been presenting a course of six lectures on nervous and mental diseases at the Morrison Hotel, Chicago, the past few weeks.

Dr. George M. Glaser, Chicago, who was assaulted in his office a month ago, offers a reward of \$500 for the arrest and conviction of his assailants.

Dr. G. C. Otrich, Captain, M. C., in the Air Service for twenty-one months, announces his return from service and resumption of practice at Belleville.

French S. Carey and Stanton A. Friedberg, Majors, M. C., U. S. Army, have returned from service with the American Expeditionary Forces in France.

Dr. E. O. Brown, after twenty-two months' service in France, paid a brief visit to his home in Clayton and returned to the service in Hoboken, N. J.

Dean D. Lewis, Lieut.-Col., M. C., U. S. Army, director of Base Hospital No. 13, at Limoges, France, for ten months, has been assigned to special duties at Fort Sheridan, Ill.

Harry D. Orr, Lieut.-Col., M. C., U. S. Army, who was promoted to Colonel and made Division Surgeon of the Thirty-third Division, has returned from Europe with the division.

Dr. Charles M. Fox of Austin has been recommended for the Distinguished Service Medal for extraordinary heroism in action. He is said to have maintained his battalion dressing station under a bombardment, only quitting when temporarily blinded by gas.

Dr. Charles A. Eames, assistant chief surgeon of the National Soldiers' Home, Danville, for seven years, has been transferred to the central branch hospital of the National Soldiers' Home, Dayton, Ohio.

Dr. R. H. Henry of Princeton, president of the Bureau County Medical Society, is again back at his office after four months' absence on account of an injury sustained in January from his car.

Albert B. Yudelsohn, Captain, M. C., U. S. A., neuro-psychiatrist to Base Hospital No. 62, has returned from France and was released from service March 27. He has resumed his practice at 29 East Madison street, Chicago.

Captain Spencer P. Blim, M. C., orthopaedic surgeon, Base Hospital, Camp Grant, Ill., honorably discharged from the U. S. Army, has lo-

cated and is practicing medicine at 1635 West End avenue, Chicago Heights, Ill.

Dr. O. W. Simpson, Captain, M. C., U. S. Army, after serving as chief of eye, ear, nose and throat service in U. S. general hospital, Chicago, has received an honorable discharge and resumed practice in Peoria.

Capt. J. W. Dunn, formerly of Dieterich, who served overseas in the Medical Corps, U. S. Army, is said to be on his way to the diamond fields of West Africa, in the service of a diamond mining company.

Major Samuel J. Walker, American Red Cross, who headed a relief commission into Bulgaria, has returned to his work in Macedonia. Major Walker is said to have been decorated by the King of Greece for valuable services in relief work.

Dr. Paul E. Davy, Paris, a member of the commission for the prevention of tuberculosis in France, who has been spending six months in the United States studying methods of tuberculosis work, spent April 22 and 23 in Springfield as the guest of Dr. George Thomas Palmer.

Dr. Frank P. Norbury, Springfield, who has been serving since August, 1918, as acting medical director of the National Committee for Mental Hygiene in New York City, in the absence of Thomas W. Salmon, Col., M. C., U. S. Army, and Frankwood E. Williams, Major, M. C., U. S. Army, has returned home.

Walter J. Sullivan, Capt., M. C., U. S. Army, who has been on service with the Fiftieth Division, Fifth British Army, since October, 1917, and who was wounded by a high explosive shell at Chemin des Dames, and after five months in a hospital was transferred to a hospital ship, and later to Malta, has returned from Europe.

News Notes

—Sending fake "bombs" to your friends or others is not good form; in fact, it will put one "in bad" with the department of justice operatives—as a woman physician learned in Chicago.

—That Arthur Earl Baker of Peoria, who practiced medicine on the license of his deceased

father and even secured a narcotic license, must be a son-of-a-gun.

—Dr. Haldane Cleminson's sentence to Joliet in 1911, on conviction of murdering his wife in 1909, has been commuted by Governor Lowden and the doctor was released from Joliet penitentiary.

—A maternity hospital will be erected by the associated Catholic charities in celebration of the seventy-fifth year of the creation of the Catholic archdiocese of Chicago. The building will cost \$100,000 and will accommodate 100 patients.

—Dr. Arthur L. Blunt, whose long defiance of the Harrison Narcotic Act scandalized the profession, exhausted every legal technicality without avail and was sentenced by Judge Landis to two and a half years in Leavenworth penitentiary, May 8.

—In recognition of the aid it received from the late Harlow N. Higginbotham, the name of the Chicago Home for Incurables is to be changed to the Higginbotham Home. Mr. Higginbotham was active in the management of the institution for thirty-eight years.

—In the competitive examination for Cook County Hospital internes, Rush Medical College secured thirty-six out of forty-five available appointments; Northwestern University Medical College, five; University of Illinois, three, and Chicago College of Medicine and Surgery, one.

—The H. C. L. received a body blow when some doctor at Joplin, Mo., proved that he could live on one loaf of whole wheat bread, three ounces of ground wheat and four quarts of water a day. It recalls the Shriner's story of the camel. But who wants to be a camel?

—Health Promotion Week received the loyal support of the medical profession. In La Salle the physicians specialized in physical examinations, to which each devoted several hours of "free clinics." In Pekin, the physicians did their stunt in talking to the school children.

—Dr. Stephen R. Pietrowicz, James A. Britton and Max Biesenthal have been appointed by the executive committee of the Chicago Tuberculosis Institute, an advisory committee for the president and members of the board of county commissioners, in matters affecting tuberculosis hospitals.

—Judge Joseph B. David, in the superior court, May 17, set aside the verdict of \$6,500, returned by a jury the previous day against Dr. Daniel A. K. Steele, in a damage suit for \$50,000 brought by Miss Dell D. Nichols, who claimed because of an operation performed by Dr. Steele she lost her voice. Judge David held that there was nothing in the evidence which would indicate that the operation was the cause of the plaintiff's misfortune.

—A handsome memorial monument, consisting of a granite boulder bearing a bronze tablet, was erected in Naperville at the grave of the late Dr. Theodore B. Sachs, June 1. Addresses were given by Dr. Robert H. Babcock, president of the Chicago Tuberculosis Institute; Dr. Ethan Allen Gray, superintendent of the Chicago Fresh Air Hospital and consulting physician to the Edward Sanatorium, to which Dr. Sach was greatly attached; and by Mrs. M. L. Aren, president of the Jewish Consumptive Relief Society.

—The Physicians' Fellowship Club, of Chicago, gave its first annual banquet and dance at the Hotel La Salle, May 26. Speakers of the evening were: Toastmaster, William Allen Pusey; "Physicians' Fellowship Club," Ferdinand H. Pirnat; "Future of the Chicago Medical Society," Ludvig Hektoen; "The Relationship of the Physicians' Fellowship Club," Noble M. Eberhart; "Medical Legislation," Charles E. Humiston; "Need of Organization of Physicians," Charles J. Whalen; "The Future of the Illinois State Medical Society," J. W. Van Derslice; "Co-operation of Physicians," Alexander H. Craig; "Illinois Hospital Association," M. L. Harris; "Fellowship Among Physicians," Hugh MacKechnie; "Illinois Medical Journal," Clyde D. Pence; "Why You Ought to Be a Member of the Physicians' Fellowship Club," J. V. Fowler.

Marriages

EMMET FRANCIS CASEY to Miss Elsa E. Singer, both of Chicago, January 8.

ABRAHAM LEAR MORRIS to Miss Fanny Reeves Ellison, both of Chicago, April 9.

OMAR OAKLEY HALL, Milford, Ill., to Mrs. Flore E. Flutro, of Paxton, Ill., at Watseka, Ill., April 22.

JOHN EDWARD KELLEY, Captain, M. C., U. S. Army, to Miss Rose Ann Gahan, both of Chicago, April 26.

C. HAROLD HEFFRON, Lieutenant, M. C., U. S. Army, Metamora, Ohio, on duty at Fort Sheridan, Ill., to Miss Elsie Lindbergh of DeKalb, Ill., at Chicago, April 8.

Deaths

JOHN G. TRINE, Chicago (license, years of practice, Illinois, 1877); aged 88; died at his home, May 14.

IRVING CLENDENEN, Maywood, Ill.; Bennett Medical College, Chicago, 1876; a Fellow A. M. A.; aged 72; died at his home, May 6.

HIRAM TENNEY HARDY, Kaneville, Ill.; Dartmouth Medical School, Hanover, N. H., 1867; aged 81; died at his home, May 7, from erysipelas.

ROBERT EDWARD MILLER, Chicago; Rush Medical College, 1880; a Fellow A. M. A.; aged 72; died at his home, May 2, from angina pectoris.

THEODORE B. REDMOND, Danville, Ill.; Indiana Medical College, Indianapolis, 1875; aged 72; died at his home, April 18, from cerebral hemorrhage.

CHARLES J. SUTTERLE, Niles Center, Ill.; Cleveland Medical College, Homeopathic, 1893; aged 59; died at his home, May 12 from retroperitoneal abscess and peritonitis following a fall.

JOSEPH MARK KEARNEY, Chicago; Rush Medical College, 1897; aged 44; formerly assistant physician at the Elgin State Hospital; died at his home, April 15, from pneumonia.

FRANCIS O. LOWE, Kewanee, Ill.; University of Illinois, Chicago, 1886; aged 57; a member of the Illinois State Medical Society; died at his home, April 27, from pneumonia.

WILLIAM ALEXANDER MELTON, JR., Warrensburg, Ill.; Northwestern University Medical School, Chicago, 1896; a Fellow A. M. A.; aged 56; died at his home, March 28.

JAMES ALBERT NOWLEN, Morrison, Ill.; Rush Medical College, 1875; a Fellow A. M. A.; New York University, New York City, 1883; aged 66; local surgeon of the Chicago and Northwestern Railway; county physician of Whiteside County since 1887; died at his home, February 12.

GEORGE S. RAINEY, Salem, Ill.; Louisville, Ky.; Medical College, 1875; a Fellow A. M. A.; aged 69; a veteran of the Civil War; major and surgeon of U. S. Volunteers, during the war with Spain; charter member and ex-president of Southern Illinois Medical Society; ex-president of Marion County Medical Society; died at his home, April 8, from pneumonia.

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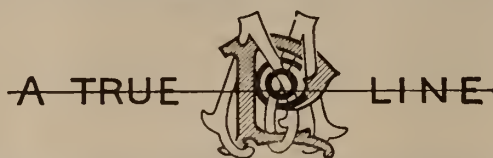
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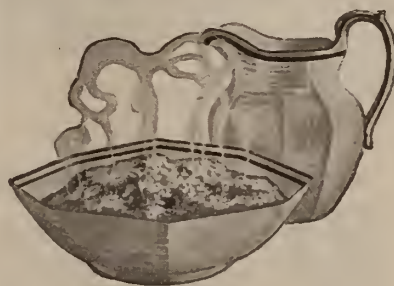
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County Secretaries are requested to notify The Journal of any changes or errors.

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(Continued on page 16)

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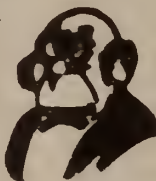
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(Continued on page 26)



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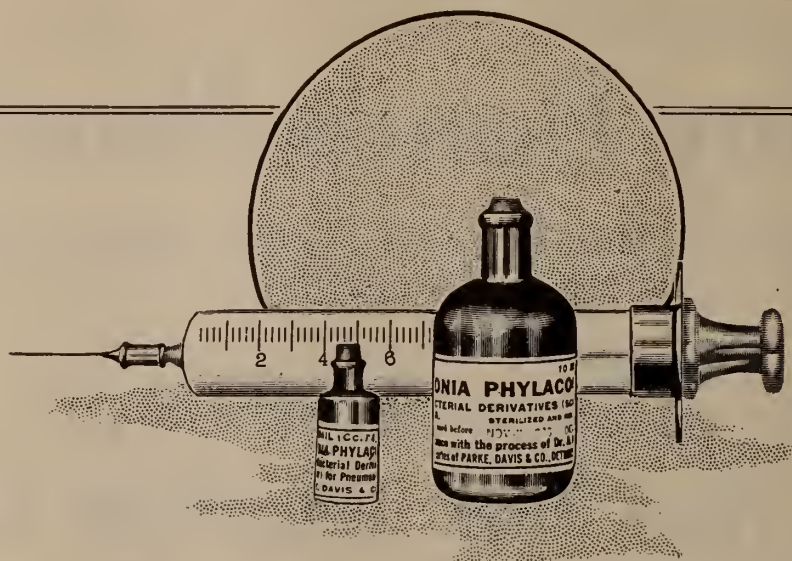
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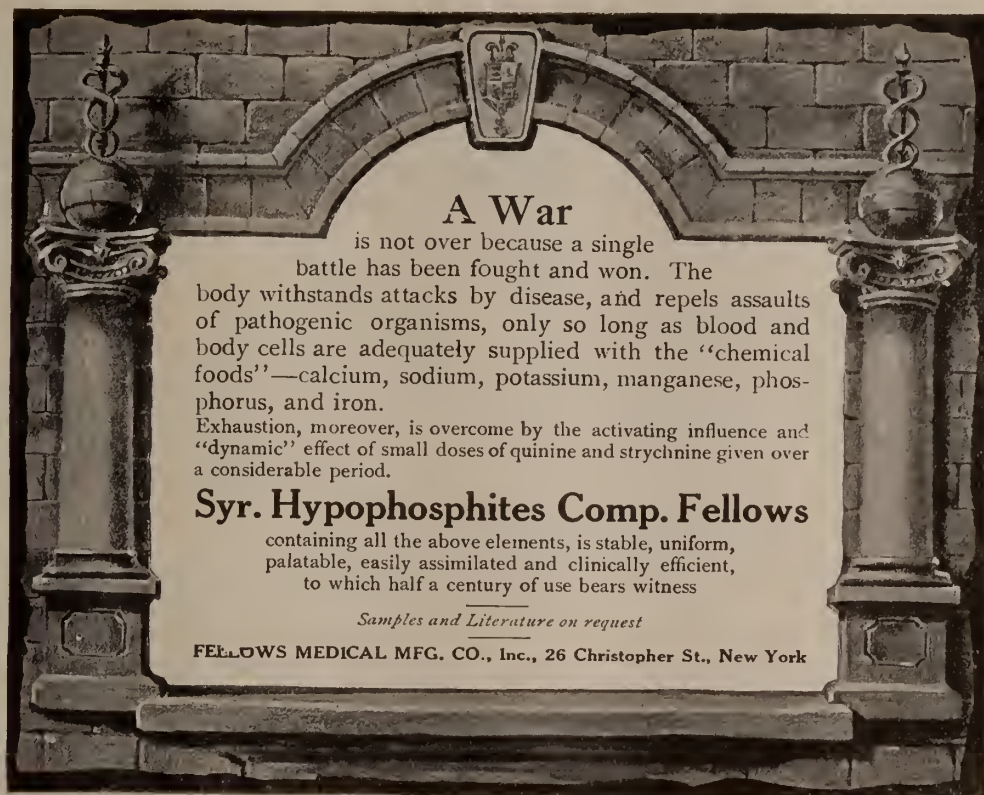
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PERSONAL HYGIENE AND HOME NURSING, A PRACTICAL TEXT FOR GIRLS AND WOMEN FOR HOME AND SCHOOL USE, by Louisa C. Lippitt, R. N., Assistant Professor of Correction Exercises, University of Wisconsin. (In New-World Science Series, edited by Professor John W. Ritchie.) Illustrated. Cloth, vii, 256 pages. Price \$1.28. Published by World Book Company, Yonkers-on-Hudson, New York.

The purpose of Miss Lippitt's textbook is to explain the means by which girls and women may attain health and happiness in the present and lay the foundations for sane and vigorous lives in after years. In clearest terms it lays down practical instructions for the conduct of their daily lives. Not only are the rules set out, but the reasons which underlie them are made clear. Directions are given for preventing the spread of infection from cases of communicable disease; and instructions are furnished for the care of oneself and one's family in cases of accident or sickness. The author has given adequate treatment to the ideas that she considers most helpful to lay readers, but she has taken pains not to go too deeply into the scientific aspects of any subject. She has desired to keep the book rather brief and for this reason has introduced only those topics on which women and girls seem particularly to need instruction.

GENITOURINARY DISEASES AND SYPHILIS. By Henry H. Morton, M. D., F. A. C. S., Clinical Professor of Genitourinary Diseases in the Long Island College Hospital; Genitourinary Surgeon to the Long Island and Kings County Hospitals and the Polhemus Memorial Clinic; Member of Committee on Venereal Disease in the Office of the Surgeon-General; Consulting Genitourinary Surgeon to the Flushing Hospital, to the Sea View Hospital of Department of Health, New York City, to the Bushwick Hospital, and to the Beth Israel Hospital of Newark, N. J.; Member of the American Association of Genitourinary Surgeons; Member of the American Urological Association; Fellow of the American College of Surgeons; Fellow of the New York Academy of Medicine, etc. Fourth Edition, Revised and Enlarged. With 330 Illustrations and 36 full-Page Colored Plates. Price, \$7.00. C. V. Mosby Company, 1918, St. Louis.

The fourth edition of Morton's Genitourinary Disease and Syphilis will be accepted by the profession as an addition to the literature of the day. The book has been written evidently with the view of giving the profession something of practical value, something from which the practitioner can obtain a clear picture of what is too often an obscure problem. We believe it to be an excellent text book for the medical student. The text is interesting, readable, fairly brief and not clouded with undefinable technical terms. It is illustrated in an excellent manner and profusely. As an every day working text on these subjects we are inclined to like it very much and recommend it to the profession.

PHYSIOLOGY AND BIOCHEMISTRY IN MODERN MEDICINE.

By J. J. R. MacLeod, M. B., Professor of Physiology in the University of Toronto, Canada; Formerly Professor of Physiology in the Western Reserve University, Cleveland, Ohio. Assisted by Roy G. Pearce, B. A., M. D., Director of the Cardiorespiratory Laboratory of Lakeside Hospital, Cleveland, O., and by others. With 233 Illustrations, including 11 Plates in Colors. Price, \$7.50. C. V. Mosby Company, St. Louis, 1918.

There has been such a woeful lack of correlation between the laboratory and the clinical case in our medical colleges that students have lost the enthusiasm for the laboratory before the clinic is reached. The laboratory courses coming mostly during the first college years, the teachers have failed largely to have the student utilize his laboratory knowledge and technique.

This work is arranged mainly for the clinician who wishes to utilize the knowledge of physiology and chemistry obtained during the earlier college years, by applying such to the pathologic cases seen in practice. It is not a book which will take the place of text books in physiology or chemistry for the medical student. It will find its field of usefulness as a supplementary volume to text books on those subjects. The book is technical but decidedly readable. It is an excellent work for the beginning practitioner.

REPORT OF THE SURGEON GENERAL, U. S. Army, to the

Secretary of War. 1918. Government Printing Office, Washington.

This report from the Surgeon General's office will be used and referred to perhaps more often than any former report. It contains a vast amount of information relative to the health of the armies, and has a large amount of data which is extremely interesting. As the health conditions of men in the various camps will be referred to so frequently in the future, there should be a large demand for copies of the report.

BOOKS RECEIVED

ANNUAL REPORT OF THE SURGEON GENERAL OF THE PUBLIC HEALTH SERVICE OF THE UNITED STATES FOR THE FISCAL YEAR 1918. Government Printing Office, Washington.

BIRTH STATISTICS. For the Registration Area of the United States. 1916. Second Annual Report. Department of Commerce, Bureau of the Census. Sam. L. Rogers, Director. Price, 20 cents. Sold only by the Superintendent of Documents, Government Printing Office, Washington, D. C. 1918.

CITY OF CHICAGO MUNICIPAL TUBERCULOSIS SANITARIUM ANNUAL REPORT. 1917. Published, August, 1918. Central Office, 105 West Monroe St., Chicago.

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IN view of the well known fact that yeast is rich in the cell-body substance, Nuclein; and in Vitamin properties, peculiar significance attaches to a special paragraph in the report of Dr. Philip B. Hawk on his investigation of the therapeutic properties of Fleischmann's Compressed Yeast.

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The results of Dr. Hawk's tests are so important that the report (Journal A. M. A., Vol. LXIX, No. 15, reprinted with added matter on the production of yeast has been distributed to physicians. If not now in your files, a copy of this pamphlet may be had on request.

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UNITED STATES NAVAL MEDICAL BULLETIN. Vol. XII. No. 5. Published for the Information of the Medical Department of the Service. Issued by the Bureau of Medicine and Surgery, Navy Department, Division of Publications. Commander J. S. Taylor, Medical Corps, U. S. Navy in Charge. October, 1918 (Quarterly), Government Printing Office, Washington. 1918.

THE ROCKEFELLER FOUNDATION INTERNATIONAL HEALTH BOARD. Fourth Annual Report. January 1, 1917-December 31, 1917. 61 Broadway, New York, N. Y., U. S. A. January, 1918.

FORTY-NINTH ANNUAL REPORT OF THE SECRETARY OF STATE ON THE REGISTRATION OF BIRTHS AND DEATHS, MARRIAGES AND DIVORCES IN MICHIGAN FOR THE YEAR 1915. Coleman C. Vaughan, Secretary of State. By Authority. Lansing, Mich., Wynkoop-Hallenbeck-Crawford Co., State Printers. 1918.

THE MEDICAL CLINICS OF NORTH AMERICA. U. S. Army Number. Volume 2. Number 2. September, 1918. Published bi-monthly by W. B. Saunders Company, Philadelphia & London.

This number of Medical Clinics is unusually interesting. While it is a military number, the topics under discussion are not of diseases peculiar to military camps, but are the conditions also met with in civilian practice. In large military camps any single condition may be met with more or less frequently, thus giving the clinician ample opportunity to study these cases of which in private practice he might see only one or two in a lifetime.

The contributors to and subjects of this number are as follows: Major-General William C. Gorgas, Surgeon-General U. S. Army, Clinical Research in United States Army Base Hospital; Major Walter W. Hamburger, M. C., and Major Herbert Fox, M. C., "A Study of the Epidemics of Pneumococcus Infections and Streptococcus Infections and Measles"; Contract Surgeon W. G. MacCallum, M. D., "The Pathology of the Streptococcal Pneumonias of the Army Camps"; Lieutenant-Colonel Channing Frothingham, M. C., "Function of a Base Hospital in a National Army Cantonment"; Major Edward H. Goodman, M. C., "Results of the Examination of 23,943 Drafted Men by the Cardiovascular Board"; Major W. W. Herrick, M. C., "Meningococcic Pericarditis, with Report of 12 Cases"; Lieutenant Morris H. Kahn, M. C., "Paroxysmal Tachycardia in Soldiers"; Major E. P. Joslin, M. C., and Major Homer Gage, M. C., "Postoperative Pneumonia"; Major Harlow Brooks, M. C., "Neuro-circulatory Asthenia, Epidemic Parotitis"; Major Francis W. Peabody, M. C., First Lieutenant Joseph T. Wearn, M. C., and Edna H. Tompkins, "The Basal Metabolism in Cases of the 'Irritable Heart of Soldiers'"; Major Lawrence Litchfield, M. C., "Notes on the Diagnosis of Acute Infections in the Thorax"; Lieutenant-Colonel Joseph L. Miller, M. C., and Captain Frank B. Lusk, M. C., "Empyema"; Major Joseph

C. Friedman, M. C., and Captain Warren T. Vaughan, M. C., "Mediastinal Complications of Measles; Methods Employed in Preventing Measles Complications"; Major Russel L. Cecil, M. C., "Pneumonia and Empyema"; Major Charles L. Mix, M. C., "Anthrax"; Major Donald J. Frick, M. C., "Cardiovascular Diseases"; Major J. M. W. Scott, M. C., "Drug Addiction"; First Lieutenant Macy L. Lerner, M. C., "Marie's Disease; Infantilism; Hyperkeratosis; Subclavian Aneurysm"; Major Thomas D. Coleman, M. C., and Captain Emmet F. Horine, M. C., "The Clinical Significance of Cardiac Murmurs"; Major Charles Spencer Williamson, M. C., "The Prevention of Communicable Respiratory Diseases."

THE SURGICAL CLINICS OF CHICAGO, December, 1918. Volume 2, Number 6. With 63 illustrations. Index Number. Published bi-monthly. W. E. Saunders Company, Philadelphia and London.

This volume, uniform with previous numbers, contains many interesting cases. The clinics of Dr. Bevan are especially interesting and are of major importance.

The clinicians and some of their cases are as follows: Dr. Arthur Dean Bevan, "Acute Necrosis of the Thyroid Gland"; "Senile Gangrene"; Stephen Smith, "Amputation at Knee"; "Undescended Testes"; "Chronic Vicious Cycle Following Gastro-Enterostomy"; "Prostatic Obstruction"; "Rupture of Urethra"; Dr. Thomas J. Watkins, "Perineorrhaphy—A Simple and Efficient Operation"; Dr. George E. Shambaugh, "Discussion of Clinical Problems Relating to Faucial Tonsils"; Dr. Albert J. Ochsner, "Compound Comminuted Fracture of Both Bones of Leg"; "Plastic on Face"; Dr. Herman L. Kretschmer, "Hematuria and Purpura"; Dr. Carl Beck, "Reconstruction of Ears and Nose"; Dr. Lewis L. McArthur, "Fibromyoma of Stomach Simulating Stomach Ulcer"; Dr. Charles Morgan McKenna, "Presentation of Three Genito-Urinary Cases"; Dr. Maurice A. Bernstein, "The Treatment of Early and Late Infections of the Hand and Fingers, with Special Reference to Tendon Transplantations."

"THAT THESE HONORED DEAD SHALL NOT HAVE DIED IN VAIN"

(Abraham Lincoln)

What President Lincoln said at Gettysburg, Nov. 19, 1863, has deep significance today. It is the paramount duty of all Americans that the 58,478 men who died for us in the great War shall not have laid down their lives in vain—that the 262,723 men who were killed, wounded or captured by the enemy shall not have made their sacrifices for naught. They fought the battles and bore the tortures of gas, fire, cold, privation, sleeplessness, and incessant peril. It was for us that they "poured out the last full measure of their devotion." Our duty is to see that the war costs are honestly and promptly paid, that the Yankees over there are as speedily as possible brought back

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and restored to the privileges and delights of home and peace.

A glance at the report of United States Treasurer Burke for the fiscal year 1918 shows that up to June 30 the Government spent \$8,966,532,266. On Nov. 27, Secretary McAdoo gave out supplementary figures covering expenditures from July 1 to Nov. 23, 1918—an additional \$8,213,070,568. The combined figures give a total of \$17,179,602,835.

These vast expenditures relating to the actual conduct of the War have already exhausted all the \$6,-866,416,300 raised by the sale of the Fourth Liberty Loan and in addition the Government has been compelled to sell nearly \$2,000,000,000 of anticipation certificates drawn (1) against the federal taxes due March 15, and (2) against the Fifth Loan. A regular programme of anticipation certificate issues has been put in operation whereby the banks of the country will supply funds at the rate of about \$1,200,000,000 a month until the Treasury is able to bring out the Fifth Loan for popular subscription.

Government expenditures are going on at the rate of \$2,000,000,000 every month. The American military and naval force numbers about 3,764,700 men. All these men must be fed and supplied with everything just the same as during the actual fighting. And the money that is necessary must be raised from day to day through the industry and thrift of the people centering in the flow of money to the banks.

The money in the banks is the money of the people,

except as to the part of it represented by the stock and surplus funds. The banks lend their credit to manufacturers and merchants who are creating new values. These values may be made the basis of issues of bank notes; but the law requires cash reserves to protect such issues, and these cash reserves must come from the savings of the people.

If every person in the country were to spend immediately all the money he received, it is evident that the money would be constantly flying from hand to hand. It would not rest long enough in the reserve vaults of the banks to serve its necessary function as "reserve" to make good the credits on which business is done.

But if every person in the country makes it a practice to save a part of all the money received as wages and interest, and if that money as soon as saved is put into the savings banks, it makes a vast total of available cash which the banks will use as the basis of credits to encourage industry and increase prosperity.

The expenses incurred in the Great War must be paid.

To do it every American must go right on saving and banking all he saves.

The success of the Fifth Loan is a matter of national necessity.

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(Continued on page 37)

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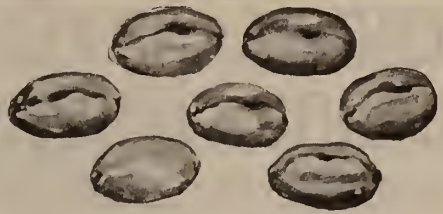
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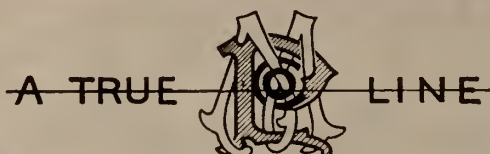
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(Continued on page 16)

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*Bloom, New Orleans Medical and Surg. Journal, Vol. 70, No. 3, Sept. 1917, page 282.

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(Continued on page 26)



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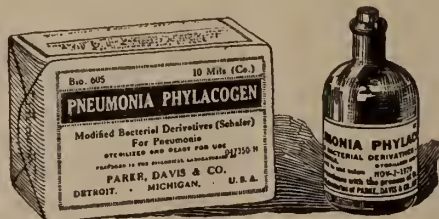
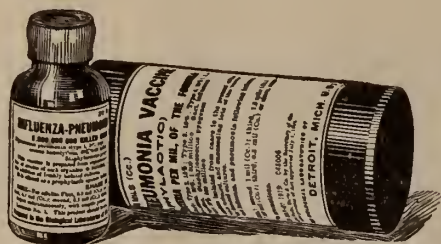
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CONVINCING evidence in support of specific prophylaxis in influenza is afforded by hundreds of reports on the use of our Influenza-Pneumonia Vaccine (Prophylactic). This vaccine, prepared in accordance with the formula of Dr. E. C. Rosenow of the Mayo Foundation, is composed chiefly of pneumococci, streptococci and influenza bacilli, all cultures being freshly isolated from cases occurring during the recent epidemic. Results from its use in military camps and other places where influenza has prevailed leave no doubt of its prophylactic value.

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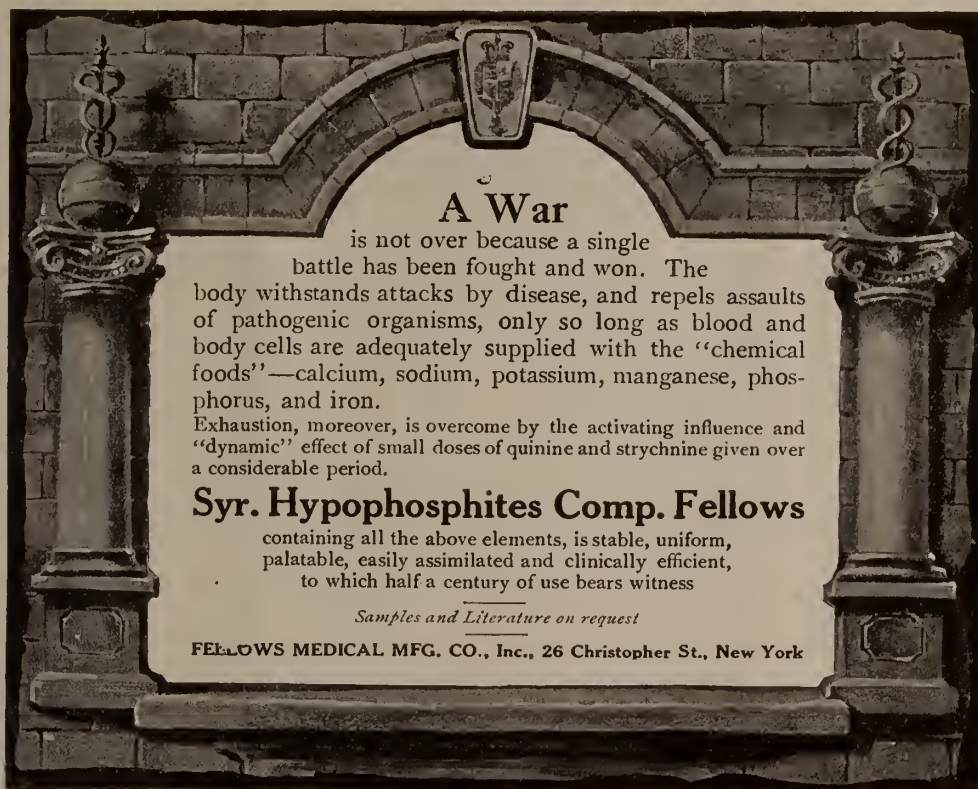
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PROOF of the efficacy of Pneumonia Phylacogen in the treatment of influenza is abundant and convincing. This Phylacogen has been used in many sections of the United States with highly satisfactory results. Cases so treated and reported during the recent epidemic number many hundreds, the percentage of recoveries being surprisingly large. One physician has used Pneumonia Phylacogen in over a hundred cases without a fatality. He gives an initial dose of Phylacogen (1 mil) with the first sign of fever, repeating in four to six hours.

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Treatment of Lobar Pneumonia With Partially Autolyzed Pneumococci— *Pneumococcus Antigen

IN the *Journal of the American Medical Association* (pages 759 to 763—March 16, 1918) Dr. E. C. Rosenow has reported results in the treatment of lobar pneumonia with partially autolyzed pneumococci.

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Book Notices

A TEXT-BOOK OF PHYSIOLOGY: FOR MEDICAL STUDENTS AND PHYSICIANS. By William H. Howell, Ph. D., M. D., Professor of Physiology, Johns Hopkins University, Baltimore. Seventh Edition Thoroughly Revised. Octavo of 1,059 pages, 307 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$5.00 net.

This seventh edition, coming only thirteen years after the first, perhaps does not bear a great resemblance to the first edition, except in the table of contents. The book primarily is a text-book for students of medicine, but not by any means limited to his needs. The physicians who graduated twenty years ago will find the volume vastly different from the one he used as a student.

To write a text-book on physiology for students requires the judgment of a master mind, with which to discriminate between the many theories. It would necessarily be impossible to include in a volume of reasonable size the many theories arising from experimental physiology. Still the student must have a clear concise text if he is to arrive at any definite knowledge.

As a reference book for the physician, it is probably not sufficiently complete. For the student it contains the facts and is all that he has time for. The work is interestingly written and is a distinct addition to medical literature.

A TEXT-BOOK OF GENERAL BACTERIOLOGY. By Edwin O. Jordan, Ph. D., Professor of Bacteriology in the University of Chicago and in the Rush Medical College. Sixth edition thoroughly revised. Octavo of 691 pages, fully illustrated. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$3.75 net.

The sixth edition of this excellent text-book on General Bacteriology is ready for distribution. It is primarily a text-book for students.

The first chapters are on the history and laboratory apparatus of bacteriology, the structure and mode of development, bacteria in disease, immunity, etc. Other chapters are on general bacteriology and a large portion of the work is devoted to pathogenic bacteria—their entrance into the human body and consequent infection.

The book is well written, clear and concise and still covers the field remarkably well. The mechanical make up is of the best.

PRINCIPLES AND PRACTICES OF OBSTETRICS. By Joseph B. Delee, A. M., M. D., Professor of Obstetrics at the Northwestern University Medical School. Third edition, thoroughly revised. Large octavo of 1,089 pages, with 949 illustrations, 187 of them in colors. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$8.50 net.

This third edition of DeLee will be still more popu-

lar than former editions. The work is much like the previous editions with addition of new material, which has accumulated during the last three years.

The volume is one of those monumental affairs which covers the field it treats of fully, and where theories are not proven the author is generous with those holding other views than his own. The work is profusely illustrated, and the illustrations are well done. The color plates are mostly fine.

While originally intended as a text-book for medical students, the author has arranged a wealth of material in a manner highly satisfactory to both student and practitioner, and the general practitioner most of all will value the book. The author is a great teacher of obstetrics, and his book is a great book. However great any book may be it must contain some things of which not all will approve.

In attending the very wealthy, whether in obstetrics, surgery or medicine, many unessential luxuries may be had, and rightly so, but in teaching that these luxuries of the wealthy are essential may place the beginning practitioner, who has a clientele composed of poorer people, in a false position, as he has learned that the luxuries are essential and with him they are impossible. Most physicians can not remain throughout a labor period of several hours' duration. Neither do most physicians have assistants to do this. Many physicians do not have a nurse who can auscultate the heart of the unborn child every hour. Neither do we think it necessary, and we do believe there are objections to it. The point is that the newly graduated doctor may find himself at a loss when he enters the homes of the poor to care for a parturient woman. He should be taught how to rely on himself and to improvise.

A MANUAL OF GYNECOLOGY. By John Cooke Hirst, M. D., Associate in Gynecology, University of Pennsylvania; Obstetrician and Gynecologist to the Philadelphia General Hospital. 12mo of 466 pages with 175 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$2.50 net.

This little book is written particularly for the medical student. It covers a rather wide field and necessarily it is brief. There is nothing superfluous, and facts are stated concisely. We do not believe the physician should make extensive use of a handbook of this character. For the classroom work of the student it would seem to fill a desired place.

A MANUAL OF DISEASES OF THE NOSE, THROAT AND EAR. By E. B. Gleason, M. D., Professor of Otolaryngology in the Medico-Chirurgical College Graduate School, University of Pennsylvania. Fourth edition, thoroughly revised. 12mo of 616 pages, 212 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$3.00 net.

This small volume, a manual of nose, throat and ear diseases, written for medical students and general practitioners, fills a rather useful requirement. The

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student who has not sufficient time to go thoroughly into a subject will find the volume a valuable aid. The busy practitioner who is not doing much nose and throat work will find the volume useful to assist him in diagnosis and in the little treatments he carries out.

PATHOLOGICAL TECHNIQUE. A practical manual for workers in Pathologic Histology and Bacteriology, including directions for the performance of autopsies and for clinical diagnosis by laboratory methods. By F. B. Mallory, M. D., Associate Professor of Pathology, Harvard Medical School; and J. B. Wright, M. D., Pathologist to the Massachusetts General Hospital. Seventh edition, revised and enlarged. Octavo of 555 pages with 181 illustrations. Philadelphia and London: W. B. Saunders Company, 1918. Cloth, \$3.75.

This manual is, strictly speaking, a laboratory guide. It seems to contain more detailed information than is usual for this type of book. Its descriptive matter is so plainly written that one grasps the meaning at once, and for that reason the practice of the various methods are much easier. The book is of value only to those interested in laboratory technique of pathology. We deem it an excellent volume for this purpose.

NEOPLASTIC DISEASES. A text-book of Tumors. By James Ewing, M. D., Sc. D., Professor of Pathology at Cornell University Medical College, New York City. Octavo of 1,027 pages with 479 illustrations. Philadelphia and London: W. B. Saunders Company, 1919. Cloth, \$10.00 net.

The first statement of the author's preface is, "It is the object of this work to present within reasonable space and in accessible form the main features of the origin, structure and natural history of tumors." This apparently has been the highest aim of the author, and has been well done, both in the written text and in the illustrations.

The author believes that the prevailing method of considering all tumors as a limited number of grand classes and that each tumor is identical with other tumors of a class, without special consideration of the organ or tissue involved, is responsible for at least some lack of progress in the study of cancer and other tumors. That is, he does not think there is a universal specific causative agent for all tumors of the same class. He studies especially the histology and histogenesis when looking for etiology.

A hurried review of this volume leads us to believe it is a distinct addition to medical literature, and that it will be one of the aids in finally determining the etiology of malignant tumors. It is interesting to a degree not usually attained in works on pathology, and whether or not you are a pathologist you will enjoy reading it.

AN INTRODUCTION TO NEUROLOGY. By C. Judson Herrick, Ph. D., Professor of Neurology in the University of Chicago. Second edition, reset. 12mo of 394 pages, 140 illustrations. Philadelphia and Lon-

don: W. B. Saunders Company, 1918. Cloth, \$2.00 net.

This little volume will be of interest chiefly to the neurologist or the student of neurology. It is not a work on neurology, but is rather a preparatory year has proved of such value as a source of information concerning the individual members of the medical treatise to that study, dealing as it does with the anatomy and physiology of the brain and nervous system and with the mental mechanism as well. For those interested in neurologic study, no doubt the book is of interest and value.

COUNCIL OF NATIONAL DEFENSE, MEDICAL SECTION, WASHINGTON

The Council of National Defense authorizes the following:

Early in February each physician in the United States, exclusive of those who served in the Medical Corps of the Army for the past two years and members of the Volunteer Medical Service Corps, received a communication from the Council of National Defense, requesting that he fill out and return promptly to the Washington office an accompanying questionnaire, so that there may be on file in Washington complete individual information covering the members of the profession. Simultaneously with the distribution of these questionnaires, state and county representatives of the Volunteer Medical Service Corps were instructed to urge all doctors in their communities to comply promptly with the request of the Council to fill out and forward promptly to Washington the blanks sent them; and to advise those who by any chance failed to receive blanks, to communicate with the Council of National Defense at once in order that application blanks might be furnished them.

The Volunteer Medical Corps was organized early in 1918 to serve the government during the emergency of war. As this emergency has ceased to exist, active membership in the corps is no longer solicited. However, the survey initiated by this organization last year of the medical profession that the Surgeons General of the Army, Navy and Public Health Service have requested the Council of National Defense to complete it so as to include every doctor in the country, in order that a permanent record of the profession may at all times be available for reference in future emergencies. Upon their completion the records will be transferred to the Surgeon General's Library, where they will be kept up to date by a force assigned for the purpose, and be accessible to all government bureaus.

Every physician is requested to cooperate with the Council of National Defense in making this record complete by returning at once the questionnaire received or by writing to the Medical Section of the Council of National Defense, Washington, D. C., and requesting that a blank be sent him if through an oversight he did not receive one.

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(Continued on page 26)

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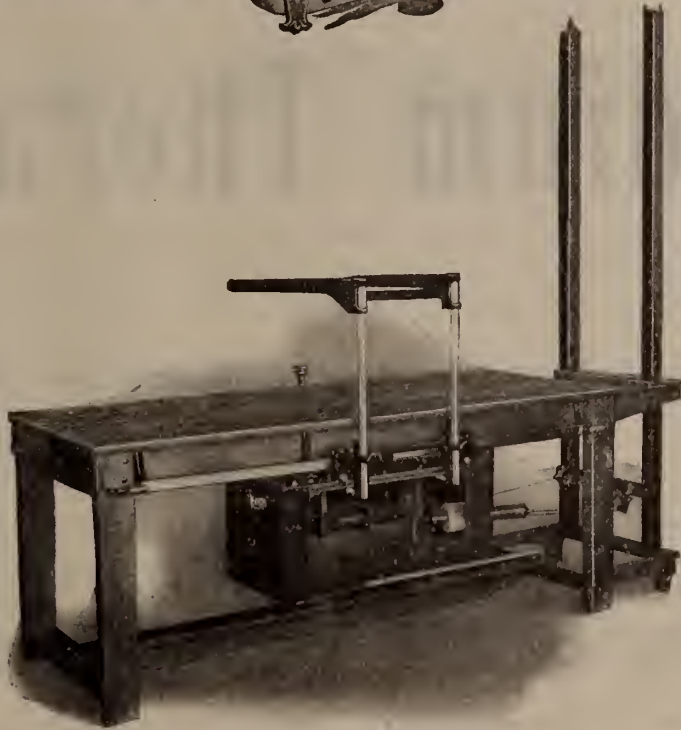
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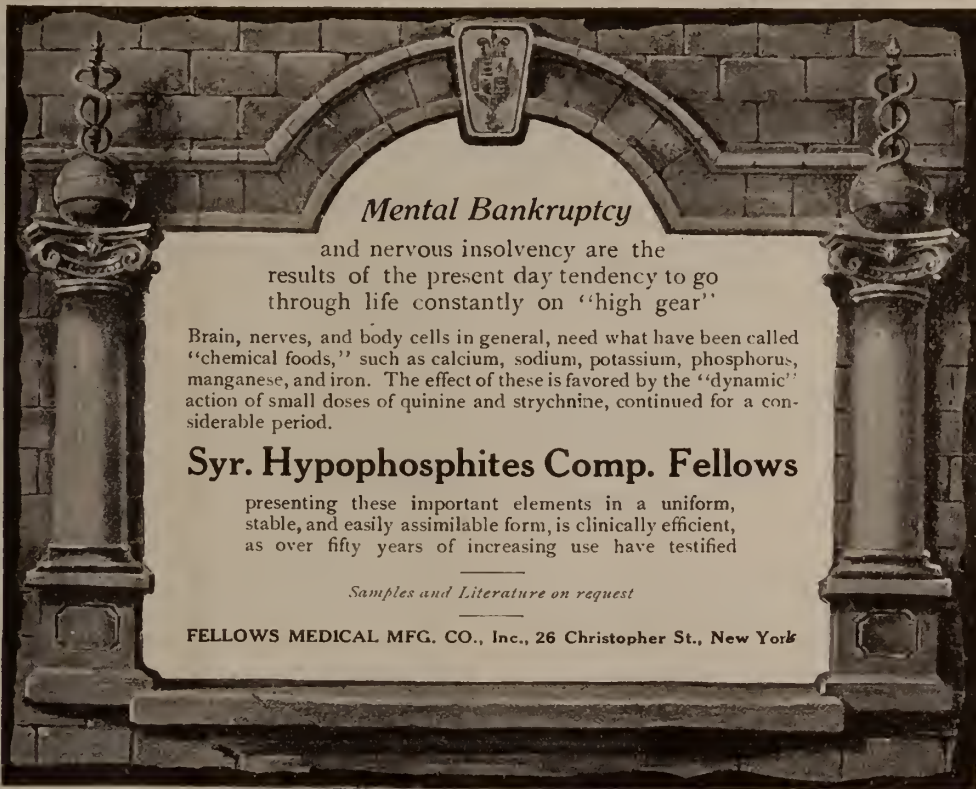
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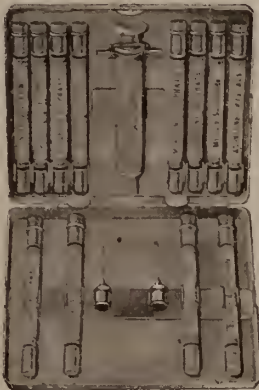
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Book Notices

THE MEDICAL CLINICS OF NORTH AMERICA. Volume II, Number III (The Philadelphia Number, November, 1918). Octavo of 275 pages with 46 illustrations. Philadelphia and London: W. B. Saunders Company. 1919. Published Bi-Monthly. Price per year: Paper, \$10.00; Cloth, \$14.00.

The Philadelphia number of the Medical Clinics is as good as any number heretofore issued. Many valuable contributions are noted, especially those on influenza. Philadelphia is to be congratulated for the success of this volume.

ROENTGENOTHERAPY. By Albert Franklin Tyler, B. Sc., M. D., Professor of Clinical Roentgenology, John A. Creighton Medical College; Attending Roentgenologist, St. Joseph Hospital, etc. With 111 illustrations. Price, \$2.50. C. V. Mosby Company, St. Louis.

This is a book intended for beginners, and it fulfills the bill. Simplicity marks it throughout. Illustrations and case reports are numerous and exceedingly helpful. For one intending to take up this branch of medicine, this volume is recommended as a reliable work.

ULTRA VIOLET RAYS IN MODERN DERMATOLOGY, Including the Evolution of Artificial Light Rays and Therapeutic Technic. By Ralph Bernstein, M. D., Philadelphia, Pa., Professor of Dermatology, Hahnemann Medical College, Philadelphia; Clinical Chief Skin Section, Hahnemann Hospital Disp., etc. Illustrated. Achey & Gorrecht, Lancaster, Pa.

This work can be called the pioneer work in America covering this field. The subject is covered thoroughly and with conciseness. The author's large experience in the field should make this work authoritative. The book, though small, is complete.

QUARTERLY MEDICAL CLINICS. A Series of Consecutive Clinical Demonstrations and Lectures by Frank Smithies, M. D., F. A. C. P., Associate Professor of Medicine, School of Medicine, University of Illinois; Gastro-Enterologist to Augustana Hospital; Medical Consultant to U. S. Marine Hospital; Formerly Gastro-Enterologist at Mayo Clinic; Fellow of the American Gastro-Enterological Association, etc. Augustana Hospital, Chicago. Published by Medicine & Surgery Publishing Co., Inc., Metropolitan Bldg., St. Louis. Annual subscription, \$5.00, paper; \$8.00, cloth.

This new series of medical clinics bids fair to become exceedingly popular and valuable, if one can take this first volume as a sample of what is to follow. These clinics are a result of a request for the preservation of the author's clinical lectures in a substantial form. Fifteen cases are described in this number, all of which are exceedingly interesting and instructive. The author is to be congratulated upon this number;

and we look forward to a continuance of this series with pleasure and profit.

SURGICAL TREATMENT. A Practical Treatise on the Therapy of Surgical Diseases for the Use of Practitioners and Students of Surgery. By James Peter Warbasse, M. D., Formerly Attending Surgeon to the Methodist Episcopal Hospital, Brooklyn, New York. In three large octavo volumes, and separate Desk Index Volume. Volume III contains 861 pages with 864 illustrations. Philadelphia and London: W. B. Saunders Company. 1919. Per set (Three Volumes and the Index Volume): Cloth, \$30.00 per set.

The third volume of Warbasse's Surgical Treatment, together with the Index, is recently from the press. The volume is, of course, uniform with the two previous volumes. It deals largely with the hernia, the male and female generative organs, amputations, etc.

To us it seems one of the best works out for the general practitioner and student of surgery. The work covers an immense number of subjects. Studying so many subjects necessitates brevity, and brevity has necessitated clearness and directness. The book is profusely illustrated and well indexed. On the whole we like it very much and recommend it.

CLINICAL MICROSCOPY AND CHEMISTRY. By F. A. McKinjin, M. D., Professor of Pathology in the Marquette University School of Medicine; formerly an Assistant in the Pathological Laboratory of the Boston City Hospital. Octavo volume of 470 pages with 131 illustrations. Philadelphia and London: W. B. Saunders Company. 1919. Cloth, \$3.50.

This book is intended for the laboratory worker rather than for the student. It is largely a compilation of laboratory methods, and deals almost exclusively with those problems of every day laboratory work. It is a book that can be used with advantage by the student of laboratory work. The manner of presentation of the work is commendable, it being clear and easy of comprehension.

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\$1.50. The Norman W. Henley Publishing Company, 2 West 45th Street, New York City. 1919.

A PRACTICAL TREATISE ON THE CAUSES, SYMPTOMS AND TREATMENT OF SEXUAL IMPOTENCE and Other Sexual Disorders in Men and Women. By William J. Robinson, M. D., Chief of the Department of Genito-Urinary Diseases and Dermatology, Bronx Hospital and Dispensary; Editor The American Journal of Urology, Venereal and Sexual Diseases, The Critic & Guide; Member American Medical Association, etc. Eighth Edition, Revised and Enlarged. 1918. Critic & Guide Company, 12 Mt. Morris Park West, New York.

The popularity of this work is evinced by the fact that it has reached its eighth edition. This work will be welcomed by the admirers of Dr. Robinson, who has presented the subject in his usual interesting and instructive manner.

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Director Trades Committee Campaign.

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The cities of Rock Island and Moline, both located in Rock Island county, Illinois, will be honored by having their names carried by two of the new vessels of the emergency fleet corporation, having won this honor as a result of securing the greatest percentage of subscribers to the Fourth Liberty loan. The Government offered as a prize to each of the five states in the Seventh Federal Reserve district the honor of having the new vessels named after the two cities of 10,000 population or over in each state making the best percentage showing based on the census of 1910. Rock Island established a record of 69 per cent distribution, with Moline a close second with a mark of 68 per cent.

Arrangements soon will be completed for the launching and christening of the new vessels, and it is expected the launchings will be the occasion of formal ceremonies with committees appointed to represent each of the cities. The committees will include members of the Liberty loan organization in each of the cities naming the honor ships.

In all of the four loan campaigns the county of Rock Island has had two separate Liberty Loan organizations, Rock Island east, including Moline, and Rock Island west, including the city of Rock Island. Both of the county organizations always have given a splendid account of their stewardship, and in every loan both districts have largely oversubscribed their quotas.

The splendid results accomplished in the last loan were credited largely to the work of the chairmen of the two county organizations, A. T. Foster of Moline, for the east district, and Frank Mixer of Rock Island, for the west district.

Other Illinois cities in the Seventh Federal Reserve district which made excellent percentage showings in the last campaign were Champaign, Champaign county, with a record of 61 per cent; Joliet, Will county, 53 per cent, and Bloomington, McLean county, 49 per cent.

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(Continued on page 27)

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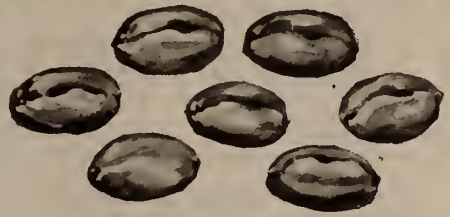
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(Continued on page 32)

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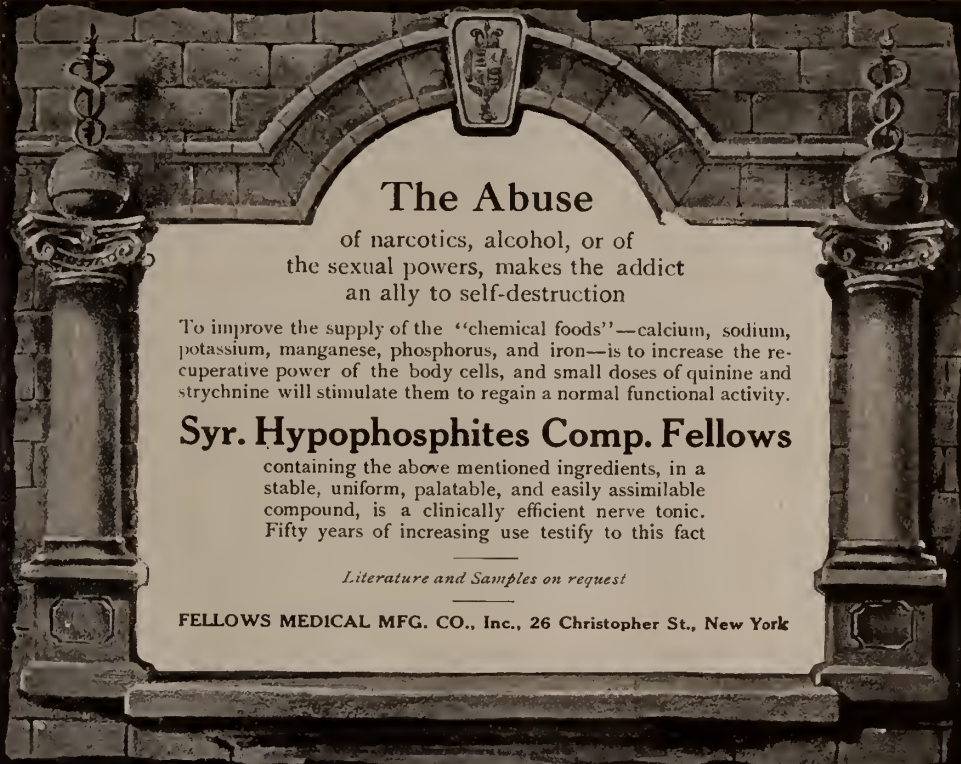
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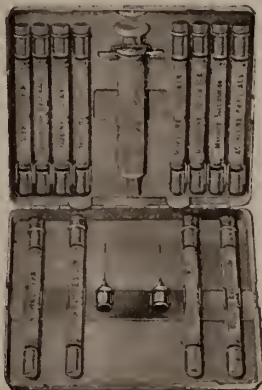
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THE SURGICAL CLINICS OF CHICAGO, Volume III, No. 1 (February, 1919). Octavo of 236 pages, 75 illustrations. Philadelphia and London: W. B. Saunders Company. 1919. Published Bi-monthly. Price per year. Paper \$10.00; Cloth \$14.00.

This February number, 1919, is the first number of volume 3. We believe these surgical clinics have proven themselves of worth. This number is, of course, uniform with previous numbers, and has many interesting clinics. We must refer particularly to the clinic of Dr. Bevan as being especially good.

The following is a list of the clinicians and some of their subjects: Contribution by Major Kellogg Speed; Contribution by Lieut. Col. Frederic A. Besley, Secondary Hemorrhages as Observed in War Surgery; Clinical Lecture by Dr. Victor D. Lespinasse, Blood Transfusion; Clinic of Dr. Carl Beck, Three Cases of Facial Plastic; Clinic of Dr. Frank Edward Simpson, Radium in Malignant Disease; Demonstration of Three Patients Treated with Radium; Clinic of Dr. Arthur Dean Bevan, Obstruction of the Ileum Due to Tuberculous Ulcerations; Injuries of the Shoulder-Joint; Treatment of Intestinal Fistula by Means of Bismuth Paste; Spina Bifida; Carcinoma of Face; Carcinoma in the Axilla; Sarcoma of the Labium; Clinic of Dr. John R. Harger, Sarcoma of the Liver; Clinic of Dr. Gustav Kolischer and Dr. J. S. Eisenstaedt, Report of Five Cases; Clinic of Dr. Charles Morgan McKenna, Report of Three Cases; Clinic of Dr. Maximilian J. Hubeny, Roentgenologic Demonstration of Several Unusual Conditions of the Genito-urinary Tract; Clinic of Dr. George E. Shambaugh, Diagnosis and Treatment of Certain Otolaryngologic Conditions; Clinic of Dr. Edward H. Ochsner, Three Cases of Sinus Disease; Clinic of Dr. Edward Louis Moorhead, Report of Four Cases; Clinic of Dr. Daniel A. Orth, Strangulated Femoral Hernia Operated Under Spinal Anesthesia; Clinic of Dr. Thomas J. Watkins, Postoperative Catheter Cystitis; Clinic of Dr. A. J. Ochsner, Hypospadias; Excision of Ganglion from hand; Clinic of Dr. Maurice A. Bernstein, Talipes Cavus.

A STEREOSCOPIC ATLAS OF PLASTIC SURGERY OF THE FACE, HEAD AND NECK. With Case Report. By Joseph C. Beck, M. D., F. A. C. S., and Ira Frank, M. D., F. A. C. S., Chicago, Ill. Price \$7.00. C. V. Mosby Company, St. Louis. 1919.

This work of Doctors Beck and Frank, while rather unique, should be an incentive first to a more complete set of stereoscopic views of plastic surgical work on living patients, and second and most important to more and better plastic surgery being done.

The small volume of text which accompanies the stereoscopic views contains several sets of photographs together with a detailed description of the work. The photographs are rather the before and after type and are good, but should be accompanied by photo-

graphs of the procedure. The photographs should also be larger as they are too small to be entirely satisfactory.

The stereoscopic views are made from the cadaver. This method perhaps shows more plainly the various steps of work, but has the disadvantage of not showing the final result.

In all it is a method of teaching which should be more in vogue.

EVERY DISABLED SOLDIER AND SAILOR SHOULD KNOW

That the Government is resolved to do its best to restore him to health, strength, and self-supporting activity.

That until his discharge from hospital care the medical and surgical treatment necessary to restore him to health and strength is under the jurisdiction of the Military or Naval authorities.

That the vocational training which may be afterwards necessary to restore his self-supporting activity is under the jurisdiction of the Federal Board for Vocational Education.

That if he needs an artificial limb or other orthopedic or mechanical appliance the Bureau of War-Risk Insurance supplies it free upon his discharge and renews it when considered necessary.

That if, after his discharge, he again needs medical treatment on account of his disability the Bureau of War-Risk Insurance supplies it free.

That any man whose disability entitles him to compensation under the War-Risk Insurance Act may be provided by the Federal Board with a course of vocational training for a new occupation.

That the Government strongly recommends each man who needs it to undertake vocational training and put himself under the care of the Federal Board but the decision to do so is optional with each man.

That if his disability does prevent him from returning to employment without training and he elects to follow a course of vocational training provided by the Federal Board, the course will be furnished free of cost, and he will also be paid as long as the training lasts a monthly compensation equal to the sum to which he is entitled under the War-Risk Insurance Act or a sum equal to the pay of his last month of active service, whichever is the greater, but in no case will a single man or a man required by his course of instruction to live apart from his dependents receive less than \$65 per month, exclusive of the sum paid dependents; nor will a man living with his dependents receive less than \$75 per month, inclusive of sum paid to dependents.

That if his disability does not prevent him from returning to employment without training and he elects to follow a course of vocational training provided by the Federal Board, the course will be furnished free of cost to him, and the compensation provided by the War-Risk Insurance Act will be paid to him, but no allowance will be paid to his family.

That in addition to the above the family or de-

Yeast Dosage

A REPORT of an investigation of the therapeutic value of FLEISCHMANN'S COMPRESSED YEAST was published in Journal A. M. A., Vol. LXIX, No. 15. This most exhaustive investigation was made at Jefferson Medical College, the Philadelphia General Hospital and the Roosevelt Hospital, New York, under the supervision of Philip B. Hawk, Ph. D.

The work of Dr. Hawk, embracing a series of very successful tests in the treatment of furunculosis, the acnes, constipation and gastro-intestinal catarrh, attracted widespread attention and many physicians have reported the successful use of FLEISCHMANN'S COMPRESSED YEAST in their practice. Many other physicians have written, asking for further details on the matter of proper dosage.

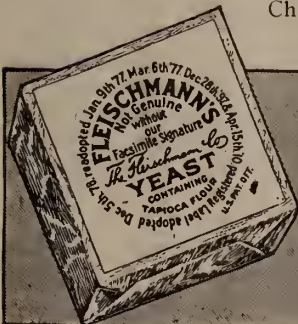
In the tests of Dr. Hawk, the usual dosage was one cake of FLEISCHMANN'S COMPRESSED YEAST administered, t. i. d., in suspension in water, fruit juices or milk, according to the preference of the patient. Dr. Hawk says: "..... yeast may be administered satisfactorily either with meals or on the empty stomach."

In a very few cases, it was necessary to reduce the dosage to half a cake of yeast, t. i. d. FLEISCHMANN'S COMPRESSED YEAST, being a most valuable remedy for constipation, has a laxative tendency. Naturally, this tendency is more pronounced in some cases than others. The physician should therefore regulate the dosage from a maximum of three cakes daily, in accordance with the laxative effect produced.

FLEISCHMANN'S COMPRESSED YEAST, identical with that used by Dr. Hawk, may be secured fresh, daily, in most grocery stores. Or, write The Fleischmann Company in the nearest large city and it will be mailed direct on days wanted.

Dr. Hawk's report, in pamphlet form, together with interesting information on the production of yeast, has been distributed to physicians. If not received by you, a copy may be had on request.

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pendents of each disabled man will receive from the Government during his period of training the same monthly allotment and allowance as that paid prior to his discharge from the Army or the Navy.

That upon completion of his course of training he will continue to receive the compensation prescribed by the War-Risk Insurance Act so long as his disability continues.

That in nearly every case, by following the advice and suggestions of the Federal Board, he can either get rid of the handicap caused by his disability or acquire new powers to replace any that may have been lost.

That if he is willing to learn and to take advantage of the opportunities to increase his skill offered him by the Federal Board he can usually get a better position than he had before entering the service.

That if he fails to take advantage of these opportunities he will find himself badly handicapped when he is obliged to compete with the able-bodied men who come back to work after the war.

That the Federal Board, through its vocational experts, will study his particular disability and advise him as to the proper course to pursue and give him free training for the occupation best suited to him.

That on the satisfactory completion of his training the Federal Board, through its employment service, will assist him to secure a position.

That public authorities and other large employers will in many cases, at least, give the disabled soldiers and sailors preference when filling vacant positions, provided they possess the training necessary to fill them.

All disabled soldiers, whether in or out of the hospital, should address their communications either to the Federal Board for Vocational Education, Washington, D. C., or to the district office of the Federal Board of the district in which he is located. The district offices of the Board are located at the following points respectively:

District No. 1: Maine, New Hampshire, Vermont, Massachusetts, and Rhode Island. Office: Room 433, Tremont Building, Boston, Mass.

District No. 2: Connecticut, New York, and New Jersey. Office: Room 711, 280 Broadway, New York.

District No. 3: Pennsylvania and Delaware. Office: 1000 Penn Square Building, Philadelphia, Pa.

District No. 4: District of Columbia, Maryland, Virginia, and West Virginia. Office: 606 F Street NW., Washington, D. C.

District No. 5: North Carolina, South Carolina, Georgia, Florida, and Tennessee. Office: Room 1404 Candler Building, Atlanta, Ga.

District No. 6: Alabama, Mississippi, and Louisiana. Office: 822 Maison Blanche Annex, New Orleans, La.

District No. 7: Ohio, Indiana, and Kentucky. Office: 906 Mercantile Library Building, Cincinnati, Ohio.

District No. 8: Michigan, Illinois, and Wisconsin. Office: 1600 the Westminister, 110 South Dearborn Street, Chicago, Ill.

District No. 9: Iowa, Nebraska, Kansas, and Missouri. Office: 517 Chemical Building, St. Louis, Mo.

District No. 10: Minnesota, North Dakota, and South Dakota. Office: Room 742 Metropolitan Bank Building, Minneapolis, Minn.

District No. 11: Wyoming, Colorado, New Mexico, and Utah. Office: 909 Seventeenth Stret, Denver, Colo.

District No. 12: California, Nevada, and Arizona. Office: 997 Monadnock Building, San Francisco, Cal.

District No. 13: Montana, Idaho, Oregon, and Washington. Office: Room 539 Central Building, Seattle, Wash.

District No. 14: Arkansas, Oklahoma, and Texas. Office: 810 Western Indemnity Building, 1000 Main Street, Dallas, Texas.

UNITED STATES PUBLIC HEALTH SERVICE HEALTH NEWS

Time to get after that early brood of flies, says the United States Public Health Service. Better to prevent the breeding of hundreds of flies now than to swat and trap millions of them in mid-summer.

* * *

The United States Public Health Service estimates that over seven million people in the United States are infected with malaria.

* * *

"Public health is purchasable," says the United States Public Health Service, and adds that a first-class health protection service can be provided for one dollar per head per year. In fact, some city health departments render excellent service at a cost of seventy-five cents per head. Let's all get together and give better support to health work in this community.

* * *

Estimates prepared by the United States Public Health Service indicate in the South the ravages of typhoid fever, tuberculosis, hookworm, and pellagra, all together are not as serious as those caused by malaria.

* * *

Still relying on the Patent Medicine Almanac? Better discard it and get the new one issued by the United States Public Health Service, Washington, D. C. Sent free on request.

* * *

Uncle Sam will provide sanatorium and hospital care for all the boys discharged from army or naval service, so far as their sickness or disability was contracted in the service of their country. The United States Public Health Service has already undertaken this stupendous task and is busily engaged in enlarging its hospital facilities all over the country. One of the sanatoria will be located at Dawson Springs, a famous health resort in Kentucky; the location of the others has not yet been determined.

* * *

The United States Public Health Service submits the following list of "our animal friends" and wonders what we propose doing about it:

Anopheles mosquitos, which carry malaria.

Aedes mosquitos, which carry yellow fever.

Laboratories and Laboratory Methods

When laboratories and laboratory methods are being discussed by scientific men who know what they are talking about, The Cutter Laboratory of Berkeley, California, has more than "honorable mention."

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Lice (with military training), which carry trench fever.

Lice (with or without military training), which carry typhus fever.

Flies, which carry typhoid fever, dysentery and other diseases.

Fleas, which carry bubonic plague.

Tsetse flies, which carry African sleeping sickness.

Hookworm, which is very much attached to man. blood pressure outfit, Leitz Microscope; medical books.

VENEREAL DISEASES IN PORTO RICO

A report from the Attorney General to the governor of Porto Rico is an interesting and valuable contribution to the study of vice and prostitution in connection with the mobilization of the National Army of Porto Rico.

Plans to call 12,000 native men to a training camp organized on the island gave occasion for a vigorous campaign for combating the social evil and the resulting venereal disease.

Records of the United States Army for Porto Rico show that during the first six months of 1899 the rate of venereal admission per thousand per annum was 467.80. In 197 the venereal admission rate for the continental army of the United States was 84.50 per thousand. The average venereal rate for the Spanish troops stationed in Porto Rico prior to the entrance of the Americans was, for the five periods from 1889 to 1893, inclusive, 338.6 per thousand; and from 1894 to 1898, inclusive, 430.8 per thousand; 1898 gave 566 per thousand. These figures are obtained from the annual reports of the War Department for the fiscal year ending June 30, 1900, part 13, which is the report of the military governor of Porto Rico, pages 598-599.

Little change had taken place during the twenty years. The first weekly report of conditions at Camp Las Casas gave 471 admissions for venereal disease among the recently drafted men, which was higher than for any other camp. Official Bulletin, August 10, 1918.

A special hospital for women was maintained by the municipality of San Juan, to register and treat public women. From July, 1912, to July 1917, 677 women were registered for the first time in that institution. During the fiscal year ending June 30, 1917, 1,540 women were clinically examined to determine whether they should be treated or given a health card. (Report of mayor of San Juan to governor, 1912-17, inclusive. In other cities of the island the police registered the women. From studies made it was shown that 95 per cent of the prostitutes were affected with venereal disease.

By keen leadership, clever direction, and proper co-operation of the police, district attorneys and judges, the attorney general, Mr. Howard L. Kern, succeeded in having the criminal laws against prostitution actively enforced. From July

1 to December 30, 1918, 1102 cases were brought before the courts and 824 convictions obtained. The sentences averaged eight or nine months each, and were imposed for periods ranging from three months to a year, according to the seriousness of the offense and the evidence adduced at the trial.

Three district jails of the island were reconstructed for women only. Complete equipments for the medical care and venereal disease treatment of these women were installed. In all the hospitals the women were treated for vermin and itch. The patients were vaccinated and treated for hookworm, which is universal. Surveys made showed that 92 per cent of the women had gonorrhea, 12 per cent had infectious lesions of syphilis, and 42 per cent more had four plus positive Wasserman reactions, although without symptoms. Treatment for the venereal diseases was instituted. The cases of gonorrhea were all improved and possibly rendered non-infectious. Salvarsan and mercury were intensively applied to the syphilitic cases. All the infectious lesions were cleared and about 50 per cent of those with four plus Wasserman reactions have had them reduced or rendered negative.

Removing these sources of infection had a wonderful effect upon the venereal disease rate at Camp Las Casas. During the first six months at this camp of 12,000 men only 32 new cases of venereal disease were acquired, which is at the rate of 6 per thousand per annum. In a report of the surgeon general of the army on the admission rate of venereal disease for 44 camps and cantonments for the six months period ending December 27, 1918, Camp Las Casas stands third lowest, with a rate of 49.7. Rates as high as 803 per thousand are recorded and the average is 189.89. These figures well illustrate the remarkable result of the rigorous enforcement of the law against prostitution on the health of this army community.

Among the recommendations of Mr. Kern to prevent a recurrence of former conditions is one to so amend the sanitation laws as to provide effective means to regulate, control and isolate persons affected with venereal disease. The present laws are inadequate. The attorney general has prepared a draft of such an act in accordance with the recommendations of the national authorities and various state boards of health.

Indeterminate sentences are recommended for those convicted of offenses against public health where it is necessary to prevent a recurrence of the offense in order to aid the health authorities in the control and treatment of venereal disease.

The attorney general endorses the efforts of the American Red Cross and other agencies to have the Chamberlain-Kahn Act amended so that Porto Rico may secure an appropriation to further the campaign against venereal infections.

ATTENTION HOSPITALS AND SANITARIA

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Interesting exhibits follow the report which show how closely the campaign in Porto Rico was followed by the authorities in Washington, and the heartiness of the support accorded. The exhibits also show that the local officials were keen in their co-operation. Personal letters and resolutions from organizations endorse the action of the attorney general, and offers to aid are numerous and sincere. Medical reports from the physicians at the jail hospitals give complete information as to the character of the diseases found and the results of specific therapy.

The attorney general is to be congratulated on his stand for public good and his report should be read in full by those especially interested in the present great movement for the abatement of the social evil and the reduction of venereal disease.

CRAZY SIGNATURES.

I look on strife as out of place; it is absurd and a disgrace, and sane men seldom need it; but I would like to climb the frame of that galoot who signs his name so no one else can read it. I think all men while dwelling here should hand out smiles and words of cheer, and sing and dance and fiddle; but I would like to use a club upon the maple headed dub whose signature's a riddle. As transient guests we tread our path and every sign of spite and wrath we ought to check and muzzle; but I'd be glad if I might slay the drooling idiotic jay whose signature's a puzzle. This sort of fellow has his gall; I hate his fancy, swirling scrawl, I simply can't abide it; I wonder why a human gink will fill his fountain pen with ink, and then get up and ride it? Oh, does he think he'll make a hit by thrown chirographic fit with asinine endeavor? And does he think that folks will say, "Beshrew us; this gymnastic jay must be absurdly clever"? My time is worth two bones a day! I need it all to earn my pay, and I rear up and grumble, and take the shotgun from the floor when I run up against the bore whose signature's a jumble.

WALT MASON.

INCOME TAX DUE

RETURNS MUST BE FILED ON OR BEFORE MARCH 15
—BILL PROVIDES HEAVY PENALTIES

Washington, D. C.—Work on the collection of \$6,000,000,000 has been begun by the Bureau of Internal Revenue. This is the estimated yield of the new revenue bill. The income tax provisions of the act reach the pocketbook of every single person in the United States whose net income for 1918 was \$1,000 or more, and of every married person whose net income was \$2,000 or more. Persons whose net income equaled or exceeded these amounts, according to their marital status, must file a return of income with the

collector of internal revenue for the district in which they live on or before March 15.

Here is what will happen to them if they don't: for failure to file a return on time, a fine of not more than \$1,000 and an additional assessment of 25 per cent of the amount of tax due.

For "willfully refusing" to make a return on time, a fine not exceeding \$10,000, or not exceeding one year's imprisonment, or both.

For making a false or fraudulent return, a fine of not more than \$10,000, or imprisonment for not more than one year, or both, together with an additional assessment of 50 per cent of the amount of tax evaded.

For failure to pay the tax on time, a fine of not more than \$1,000 and an additional assessment of 5 per cent of the amount of tax unpaid, plus 1 per cent interest for each full month during which it remains unpaid.

In addition to the \$1,000 and \$2,000 personal exemptions, taxpayers are allowed an exemption of \$200 for each person dependent upon them for chief support if such person is under eighteen years of age and incapable of self-support. Under the 1917 act, this exemption was allowed only for each dependent "child." The head of a family—one who supports one or more persons closely connected with him by blood relationship, relationship by marriage, or by adoption—is entitled to all exemptions allowed a married person.

The normal rate of tax under the new act is 6 per cent of the first \$4,000 of net income above the exemptions, and 12 per cent of the net income in excess of \$4,000. Incomes in excess of \$5,000 are subject also to a surtax ranging from 1 per cent of the amount of the net income between \$5,000 and \$6,000 to 65 per cent of the net income above \$1,000,000.

Payment of the tax may be made in full at the time of filing return or in four installments, on or before March 15, on or before June 15, on or before September 15, and on or before December 15.

Revenue officers will visit every county in the United States to aid taxpayers in making out their returns. The date of their arrival and the location of their offices may be ascertained by inquiring at offices of collectors of internal revenue, postoffices and banks. Failure to see these officers, however, does not relieve the taxpayer of his obligation to file his return and pay his tax within the time specified by law. In this case taxpayers must seek the Government, not the Government the taxpayer.

One thing is sure: If the people do not buy the Government bonds it will be necessary to raise all the money by taxation. And tax receipts have no coupons.

Save rigidly. Buy War Savings Stamps. Lay up money to buy Fifth Loan bonds.

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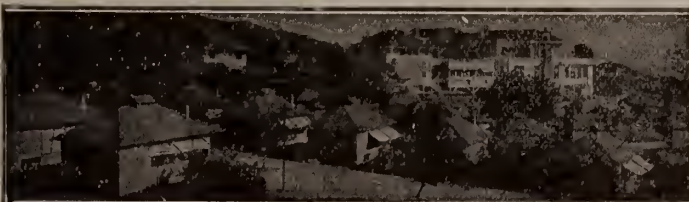
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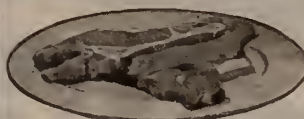


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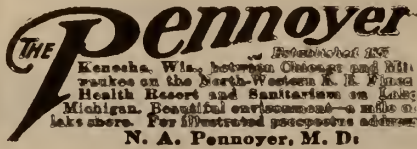
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Technic: Do not dilute this solution. Break ampoule, draw into all-glass syringe and attach a 23 to 25 gauge hypo needle. Use tourniquet or have the patient grasp the arm with his free hand until the veins at the bend of the elbow stand out prominently; run the needle into the vein quickly. Blood usually comes back into syringe back of needle or can be drawn back to be certain that needle is in the vein; release pressure, then inject slowly.

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It is the most positive and prompt means of raising blood count and hemoglobin contents, resulting in rapid disappearance of the subjective and objective symptoms associated with anemias.

The ordinary type of secondary anemia responds with normal blood count in thirty to forty days, results that heretofore required three to four months to accomplish. These cases usually require six injections at four to five day intervals.

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When used to assist the specific treatment of infections, results will indicate added importance to the blood contents in combating bacterial invasions.

We submit the following chart as illustrating the practical possibilities from the use of this solution.

Abstracted from an article entitled "The Treatment of Chronic Anemias."—*New York Medical Journal*, February 15, 1919.

Mr. S.—Referred by Dr. Satenstein in 1916. Arteritis obliterans, both lower extremities. Toe scraped at People's Hospital, followed by recurrent gangrene; same toe amputated at Beth Israel Hospital, then treated with diathermia; four months later able to dance again (professional). Returned in 1918 again; toes blue with dark spots, marked anemia. Five doses of iron and arsenic.

Sept. 19th, red blood count 4,-500,000. Hemoglobin 55.

Oct. 25th, red blood count 5,-800,000. Hemoglobin 85.

Mr. A.—In August, at Atlantic City. Ptomaine poisoning, a former urethritis reappeared, treated with serum until November, when he came under my observation; marked anemia and loss of thirty-eight pounds, joints swollen and painful, urethral discharge still present; Nelisser intracellular, iron and arsenic alternated with Sodinn Iodide intravenously.

Oct. 23d, red blood count 3,-200,000. Hemoglobin 55.

Dec. 24th, red blood count 5,-650,000. Hemoglobin 92.

Mrs. A.—General anemia for some time, lost much weight, menstruation deferred. Could find no special reason for anemia. Five cc. iron and arsenic every fifth day, six doses.

Oct. 15th, red blood count 3,-500,000. Hemoglobin 60.

Nov. 28th, red blood count 4,-500,000. Hemoglobin 95.

Mrs. W.—Secondary anemia due to loss of blood from uterine fibroid.

Aug. 1st, red blood count 3,-000,000. Hemoglobin 45.

Sept. 10th, red blood count 4,-300,000. Hemoglobin 90.

Miss F.—Marker anemia, following treatment for extreme obesity. Five cc. iron and arsenic weekly for seven weeks.

Aug. 1st, red blood count 4,-000,000. Hemoglobin 65.

Sept. 10th, red blood count 5,-000,000. Hemoglobin 95.

Mrs. G.—Influenza, followed by pneumonia; four weeks later still anemic. Solution of iron and arsenic, five cc. every fifth day.

Oct. 28th, red blood count 4,-000,000. Hemoglobin 55.

Nov. 28th, red blood count 4,-850,000. Hemoglobin 90.

Mrs. McK.—Anemia following influenza and pneumonia. Bland's mass, iron tonics failed. Five cc. iron and arsenic, six doses.

July 1st, red blood count 4,-000,000.

Aug. 26th, red blood count 4,-800,000.

Mr. O.—Influenza, August, 1918, followed by pneumonia. Slow recovery, anemia. Six doses of iron and arsenic.

Sept. 23d, red blood count 3,-700,000. Hemoglobin 58.

Nov. 10th, red blood count 5,-400,000. Hemoglobin 88.

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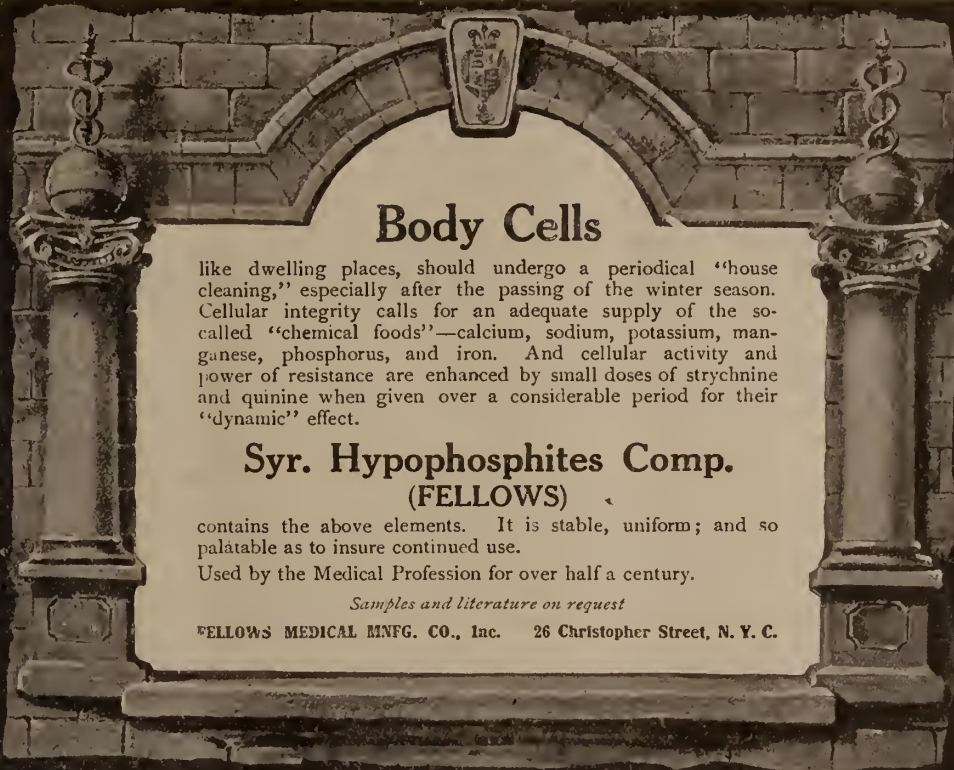
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Book Notices

MILITARY SURGERY OF THE EAR, NOSE AND THROAT.

By Hanau W. Loeb, M. D., Major, Medical Reserve Corps, U. S. A., St. Louis, Mo. Medical War Manual No. 8. Authorized by the Secretary of War and under the supervision of the Surgeon General and the Council of National Defense. Price \$1.25. Lea & Febiger, Philadelphia & New York, 1918.

This little manual is uniform in style with other volumes of this series. It covers a rather large number of subjects as they pertain to war injuries. These volumes were perhaps useful to the medical man in the field, but they are not sufficient for post war service.

HUMAN INFECTION CARRIERS. Their Significance, Recognition and Management. By Charles E. Simon, B. A., M. D., Professor of Clinical Pathology in the University of Maryland School of Medicine and The College of Physicians and Surgeons, Baltimore, Maryland. Price, \$2.25. Lea & Febiger, Philadelphia and New York, 1919.

Human infection carriers is a subject of which the profession knows little. It is a comparatively new study and as yet undeveloped.

That chronic carriers of infections are not uncommon, that they are frequently badly treated or not treated at all, is beyond dispute. The damage done by those carriers, in our mind, depends largely upon the variety of pathologic germs. That a typhoid carrier is a positive menace admits of no argument.

The author studies many of these specific disease carriers and discusses the method of discovery, treatment, dangers and cure. He also cites many cases of disease undoubtedly spread by carriers. It is a book for the general practitioner to read.

A TEXT-BOOK OF PRACTICAL THERAPEUTICS With Especial Reference to the Application of Remedial Measures to Disease and Their Employment upon a Rational Basis. By Hobard Amory Hare, M. D., B. Sc., Professor of Therapeutics, Materia Medica, and Diagnosis in the Jefferson Medical College of Philadelphia; Physician to the Jefferson Medical College Hospital; One-Time Clinical Professor of Diseases of Children in the University of Pennsylvania; Surgeon, U. S. N. R. F. Seventeenth Edition, Enlarged, Thoroughly Revised, and Largely Rewritten. Illustrated with 145 Engravings and 6 Plates. Price \$5.50. Lea & Febiger, Philadelphia and New York, 1918.

The author in his preface says, "At the present time scientific investigation has all the enthusiasm of youth and little of the judgment of age." This would seem especially true of new work on therapeutics. "Frequently the laboratory investigator is shown to be as liable to fallacy as the bedside student." One trouble with our therapeutists is they are looking for specific remedies and discard many things of value

because they are not specifics in the fullest sense. This is the mistake which modern science is leading us into. Possibly the fact that now the medical man has so many drugs, remedies and appliances in his armamentarium is the reason that he does not sufficiently study the results obtained from anyone. Certainly Hare cannot be accused greatly because of these tendencies, because he has held on well to the old which was good.

The author discusses those things which the war has brought to attention, including the treatment of shock, proper methods of intravenous injections and direct transfusion, the use of Dakin's fluid—Dichloramine T—by Carrell's methods and the treatment of burns by paraffine are discussed.

Hare's Therapeutics is too well known to require a reviewer's opinion. Its known and continued popularity place it in the front ranks of medical literature, and the medical library is out of date which does not contain it.

THE BLIND. Their Condition and the Work Being Done for Them in the United States. By Harry Best, Ph.D., Author of "The Deaf: Their Position in Society and the Provision for Their Education in the United States." The MacMillan Co., New York. 1919.

The title page seems to tell just what this book is. A hasty review indicates that the author has studied the situation relative to the blind in a rather wide manner. He starts out with a general review of the blind and their position in society, and then discusses prevention of blindness, provisions which have been made for the education of blind children, the vocational education of the blind, the material provisions which have been made for them, organizations which are working for the general welfare of the blind and a review of the entire situation. The book is interesting and readable.

A TREATISE ON ORTHOPAEDIC SURGERY. By Royal Whitman, M. D., M. R. C. S., Eng., F. A. C. S., A Director of Military Orthopaedic Teaching; Chairman of the Medical Advisory Board for Orthopaedics in New York City; Associate Surgeon to the Hospital for Ruptured and Crippled; Orthopaedic Surgeon to the Hospital of St. John's Guild; etc., etc. Sixth Edition, Thoroughly Revised. Illustrated with 767 Engravings. Price, \$7.00. Lea & Febiger, Philadelphia and New York. 1919.

The most encouraging signs of the times so far as surgery goes are the efforts of conservation and reconstruction. It is not strictly a war measure, because this work started earlier. The large number of cripples, resulting from anterior poliomyelitis, probably has had much to do in bringing forward this line of work. Formerly many surgical operations were done sacrificing limbs, where persistent orthopaedic conservation would have given more satisfactory results.

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 (Continued on page 37)

This work is a sixth edition, thereby showing the author's popularity. The book is well written, and treats of all the commoner deformities. It is profusely illustrated, and the illustrations are such that impart a clearer meaning to the text.

It is quite probable that every doctor should pay more attention to orthopaedic cases and cure them. This text book is an excellent one to study methods from, and we recommend it.

DRY TIME DRINKS

What shall we drink when comes July? We hear the thirsty people cry, the friends of old John Barleycorn, who'll sadly miss their frequent horn. In time they'll hit the babbling stream whose waters in the sunlight gleam; at some far day that drink will please, but they would reach it by degrees; a sudden change from booze, gadzooks, to sniffers from the babbling brooks, would give their works too hard a jolt and cause interior revolt. But there are drinks for every toff with which that gent may taper off. Tabasco sauce is rich and hot and hair restorers hit the spot, remove from weary hearts the care and sometimes grow pink whiskers there. And there are divers colored inks which some regard as tempting drinks. Good writing fluid, blue or black, sends pleasant thrills along the back and makes a man so full of vim he'd tear a bobcat limb from limb. When I quit booze I often yearned for something strong

that jarred and burned, and then I'd sip some turpentine and found its action very fine. I sampled all the drinks in view from linseed oil to liquid glue and finally was reconciled to lapping up the waters wild. And now I would not trade my well for all the booze this side of Hannibal, Mo. WALT MASON.

ALL AROUND THE CHURCH

"The Creed and the Curse of Bolshevism" was the subject of a sermon by the Rev. James Shera Montgomery in the Cavalry Baptist Church.

—*Social Service Review*

Probably the infantry were marshaled in the Sunday school.

Perhaps the can(n)ons might be heard in the cathedral.

No doubt the aviators were maneuvering "In excelsis."

But one would hardly expect submarines even in a Baptist "font."

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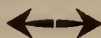
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FROM PUBLICITY DEPARTMENT, WAR SAVINGS ORGANIZATION FOR ILLINOIS

Establishment of War Savings and Thrift Stamp agencies "wherever money passes over the counter" is the aim of a big drive to be undertaken by the War Savings Organization for Illinois the week of June 2. This will be the first intensive state-wide campaign of the War Savings organization since the closing days of last year.

Secretary of the Treasury Glass believes the only compulsion in the purchase of War Savings Stamps should be self applied, but it is necessary to facilitate the practice of thrift which is being made a happy habit by the new savings appeal based on enlightened self-interest.

The drive for agencies will make it easier for savers to invest their savings. By shortening the distance between the inclination to save and the actual purchase of a Thrift or War Savings Stamp—and this can be done only through the establishment of many agencies—the War Savings Organization expects to head off many temptations to spend foolishly.

All postoffices and many banks already are agents for War Savings Stamps and there are about 6,000 other authorized agencies in the state. During the week's drive Campbell Marvin, state superintendent of agencies, expects to set up machinery for the sale

of stamps in all hotels, department stores pharmacies, grocery stores, markets, cigar and candy stores—in fact, wherever anything is sold. In this the War Savings Organization will have the co-operation of many large wholesale concerns whose salesmen will endeavor to establish agencies in each business house or hotel they visit. Life insurance agents also will be active in the campaign.

Several thousand commercial travelers and insurance men will render gratuitous service, but their interest will be stimulated and a competitive spirit aroused by a series of prizes offered by the War Savings Organization.

There will be six cash prizes, two of \$25, two of \$15 and two of \$10. One set is for the largest number of agencies established with an initial order for at least \$15 worth of War Savings and Thrift Stamps, and the other for the largest number of bona fide applications for agencies. To the worker setting up ten agencies a silver honor button will be awarded and there will be twenty-five gold buttons for those establishing the greatest number. A banner will be awarded to the business house whose salesmen attain the highest percentage with honor buttons, each silver button counting five points and each gold emblem 100 points.

A distinctive window sign and a pictorial news service is being prepared for the sales stations.



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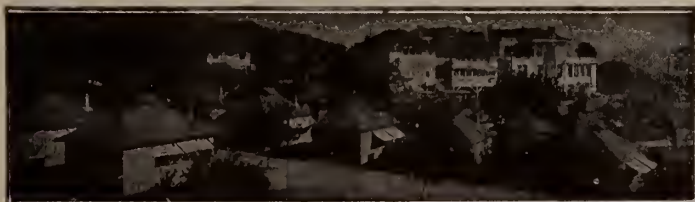
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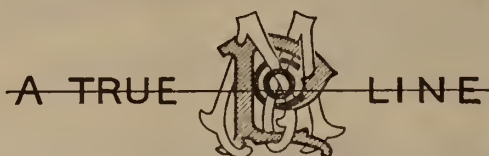
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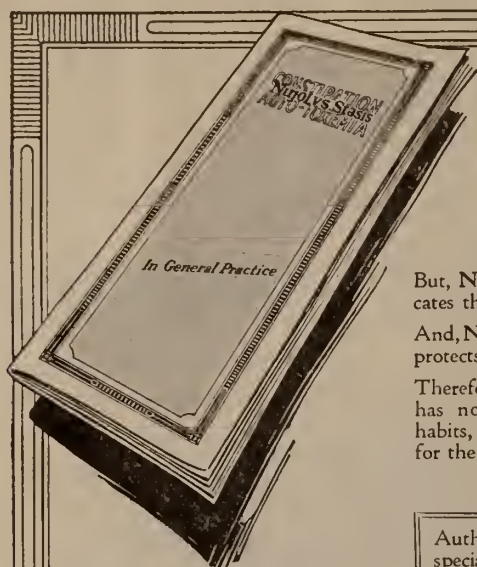
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INFLUENZA (with its sequela of pneumonia) is said to have caused more deaths than occurred in the American army in France. It is still widely prevalent. Fresh outbreaks are reported in many places where the epidemic was thought to have subsided. Danger lurks everywhere.

The situation demands that every possible precaution be observed.

Prophylactic vaccination is the rational procedure. In one locality, where several thousand persons were vaccinated before the appearance of symptoms, not a single death occurred.

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This vaccine, the formula of which was suggested by Dr. Rosenow, is offered to the medical profession with confidence in its efficacy as an immunizing agent. It is composed of cultures newly isolated from cases occurring during the prevailing epidemic. Each mil (Cc.) contains five billion bacteria, in these proportions:

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Diplococcus pneumoniae, type II	750 millions
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Streptococcus hemolyticus	1000 millions
Bacterium influenzae (Pfeiffer)	500 millions
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Book Notices

THE PHYSICIAN'S VISITING LIST (Lindsay & Blakiston's) for 1919. Sixty-eighth Year of Its Publication. Prices range from \$1.25 to \$2.50. Sold by all Booksellers and Druggists. P. Blakiston's Son & Co., 1012 Walnut Street, Philadelphia.

This visiting list is uniform with former editions and it contains the usual tables of information. It has an excellent dose table.

SURGICAL TREATMENT. A Practical Treatise on the Therapy of Surgical Diseases for the Use of Practitioners and Students of Surgery. By James Peter Warbasse, M. D., formerly Attending Surgeon to the Methodist Episcopal Hospital, Brooklyn, N. Y. In three large octavo volumes, and separate Desk Index Volume. Volume II contains 829 pages with 761 illustrations. Philadelphia and London: W. B. Saunders Company. 1918. Per set (Three Volumes and the Index Volume): Cloth, \$30.00 per set.

The second volume of Surgical Treatment by Warbasse is out. This volume treats of the surgery of the head, spine, neck, thorax, the breast and the abdomen.

This work is a monumental affair and covers the entire field of surgical treatment in a way that is pleasing. It seems innumerable operations are described and technique given for each. The text is always right to the point—clear and concise. The work is well illustrated, both schematic and by photograph. In the chapter on treatment of spinal conditions the illustrations are especially notable.

This work should be in the library of every medical man or medical student.

MENTAL DISEASES. A Handbook Dealing with Diagnosis and Classification. By Walter Vose Gulick, M. D., Assistant Superintendent Western State Hospital, Fort Steilacoom, Wash. Illustrated. Price \$2.00. C. V. Mosby Company, St. Louis. 1918.

This small volume is a sort of elementary work on disordered mentalities. It will be found rather convenient for the practitioner in making a diagnosis, or for his review before going upon the witness stand. The "psychiatrist" will not find it as complete as he wishes.

CLINICAL MEDICINE FOR NURSES. By Paul H. Ringer, A. B., M. D., Member of Staff of the Asheville Mission Hospital, Asheville, N. C., and of Biltmore Hospital, Biltmore, N. C. Illustrated. Price \$2.00 net. 1918. F. A. Davis Company, Publishers, Philadelphia. English Depot, Stanley Phillips, London.

This little volume, written especially for the teaching of this branch to nurses in training, seems

admirably adapted for the purpose. Bacteriology and pathology have been but briefly mentioned. Symptoms and their meaning have been given greater prominence, and treatment has been given only in a general way. We rather like the book.

INFORMATION FOR THE TUBERCULOUS. By F. W. Wittich, A. M., M. D., Instructor in Medicine and Physician in Charge Tuberculosis Dispensary, University of Minnesota Medical School; Visiting Physician, University Hospital, Minneapolis, Minn. Price \$1.00. C. V. Mosby Company, St. Louis. 1918.

This small volume is not intended for the medical profession, but rather for the tuberculous patient. It consists of talks for the laity on tubercular subjects. For the tuberculous patient it will answer many of the questions which perplex him.

THE SURGICAL CLINICS OF CHICAGO, Volume II, Number 5 (October, 1918). Octavo of 193 pages, 87 illustrations. Philadelphia and London: W. B. Saunders Company. 1918. Published Bi-Monthly. Price per year: Paper, \$10.00; Cloth, \$14.00.

This October number of Surgical Clinics, while not as voluminous, is full of interest.

The following are the clinicians and the subjects they have chosen to discuss: Dr. Arthur Dean Bevan—Congenital Wry-Neck, Desmoid Tumor of the Abdominal Wall, Epithelioma of the Leg, Ulcer of Stomach on Lesser Curvature, Abscess of Lung; Dr. Daniel N. Eisendrath—A Clinical Lecture on the Acute Abdomen; Dr. Charles Louis Mix—Gastric Carcinoma; Dr. Emmet A. Printy—Demonstration of a Perfected Technic for Posterior Gastro-enterostomy and for Cholecystotomy; Dr. Edward L. Moorhead—Exstrophy of the Bladder—three cases, Surgical Research Reports; Dr. Charles Morgan McKenna—A Clinic on Genito-Urinary Surgery: Case I—Papilloma of Bladder, Case II—Kidney Stone, Case III—Ureteral Stone, Case IV—Acute Epididymitis; Dr. Thomas J. Watkins—Presentation of Cases Treated by Radium for Hemorrhages Due to Benign Causes; Dr. Charles B. Reed—An Obstetric Clinic; Dr. Charles A. Parker—The Treatment of Neglected Club-Feet; Dr. Maurice A. Bernstein—Teno-Peritendinous Transposition; Dr. Albert J. Ochsner—Bilateral Griggs-Stokes Amputation.

WHAT ARE YOU WORTH TO YOURSELF?

To help every American to find the answer the government has asked that January 1, 1919, be nationally observed as "Personal Inventory Day." It is suggested that every man, woman and child take account of his or her personal property, savings and debts, and make plans for twelve months of getting ahead during 1919. The plans can be put into effect by the purchase of 1919 War Savings Stamps, which go on sale January 1.

Gastro-intestinal Catarrh

THAT FLEISCHMANN'S COMPRESSED YEAST (Species *Saccharomyces Cerevisiae*) possesses active curative properties in the treatment of gastro-intestinal catarrh seems to be one of the established conclusions in an exhaustive investigation at Jefferson Medical College, the Philadelphia General Hospital and the New York Roosevelt Hospital.

The tests were conducted by Philip B. Hawk, Ph. D., and associated physicians, and reported by Dr. Hawk in the Journal A. M. A. Vol. LXIX, No. 15.

Dr. Hawk says: "In all of our tests, we used Fleischmann's Compressed Yeast, as that is the best known and most widely used yeast."

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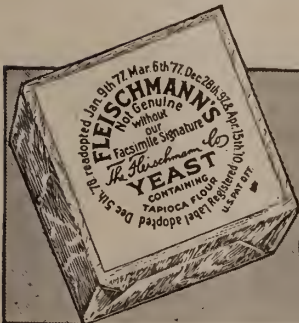
A reprint of Dr. Hawk's report, with added matter on the production of the yeast, has been distributed to physicians. If not on your files, a copy may be had on request.

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The Savings Division of the United States Treasury Department has devised two simple forms, one to be filled out by adults, and the other, which might be called a "Patriotic Estimate Blank," is equally useful for both children and grown-ups. Those directing the project realize that one of the hardest things a person has to do is to be financially honest with himself, but it is believed the blanks will help any citizen to obtain an accurate enough account of his personal financial status.

Teachers will be asked to encourage their pupils to fill out the patriotic estimate blanks for themselves. The other blank may be filled out by the family for its own guidance. The forms are not to be sent to or filed with any person or organization. They should be kept by the family as a record of its financial standing—as a guide-post to a year of thankful thrift.

A statement, urging the taking of a personal inventory, issued by the Savings Division, follows:

"Your savings increase your property and personal capital. Would not your family be interested to list all the property it owns, in order to find out just how much capital it really possesses? Your capital includes not only your house, furniture, etc., but the money you have deposited in the building and loan society, savings bank, and the Liberty Bonds, Thrift Stamps and War Savings Stamps you have purchased, as well.

"The nation has been taught the value of thrift, wise buying, sane saving, secure investment—by the war. We must not suffer a relapse. Our part in the future prosperity of our country is as great as the part we took in winning the war. One of the best ways in which to assist in insuring prosperity is by practicing thrift. A thrifty nation is a prosperous nation.

"It is with the idea of stimulating increased interest in saving that the special forms for the guidance of children, adults and families in making their personal inventories have been issued. After you have filled out the first form, and ascertained your exact patriotic financial status, fill out the second blank and make your plans for a year of greater thrift in 1919."

The forms of "stock taking" recommended by the Government Savings —

Service. The Surgeon General points out that in the first draft about one-third of the men examined were rejected for physical disability, and that hundreds of thousands will be added as a result of the examinations to be made of the new registrants.

"It is highly desirable," said Surgeon General Blue, "that the men found to be disqualified for military service by the examining physicians of the local draft boards should receive definite instructions as to the meaning of their disabilities and that a strong appeal be made to them to correct these disabilities as far as possible. But the object of this measure is not only to reclaim men for military service or for such service as they can perform, but to lessen the burden of illness and disability among those engaged in essential industrial work. It is hoped that the instruction in this circular, which is really a primer of the physical defects of the nation, will reach far beyond the draft board and be utilized by all agencies interested in improving the public health to instruct the people with regard to their physical deficiencies and the ways and means by which they can be remedied."

According to the U. S. Public Health Service experience everywhere shows that the proportion of persons with physical impairments is considerably greater in persons between 30 and 40 than in those between 20 and 30 years of age. This waning vitality at ages over 30, so commonly accepted as inevitable, can be postponed to a large extent. In this connection, it is pointed out that 60 per cent of the physical defects found in the last draft were of a preventable or curable nature.

In addition to furnishing all the local draft boards throughout the country with a sufficient number of the circulars to supply one to each registrant rejected because of physical disability, arrangements have been made to furnish specimens of the circular to life insurance companies, fraternal organizations, labor unions, employers of labor and others who desire to reprint the circular in its present official form for wider distribution.

"The U. S. Public Health Service will be glad to furnish specimens of this circular on application and urges all organizations that can reach large groups of people to reprint and distribute the circular and thus contribute materially to the public welfare and the national defense."

The circular issued by the U. S. Public Health Service is entitled "Information for Guidance and Assistance of Registrants Disqualified for Active Military Service Because of Physical Defects." It is a four-page leaflet, containing specific information relating to the commoner causes of rejection or deferred classification, e. g. Defective Eyesight, Teeth and Disease, Feet, Underweight, Overweight, Hernia, Hemorrhoids, Varicocele, Varicose Veins, Bladder, Kidney and Urinary Disorders, Ear Trouble, Heart Affections, High Blood Pressure, Lung Trouble, Rheumatism, Venereal Disease, Alcohol, Nervous and Mental Disease, and Miscellaneous Conditions. The in-

HEALTH INSTRUCTORS THROUGH DRAFT BOARDS.

WASHINGTON, D. C., Sept. 23.—Provost Marshal General Crowder today called attention to a circular of instructions prepared by the United States Public Health Service for registrants declined in the draft because of physical disability. The circular, copies of which have been placed in all the local draft boards throughout the country, is the result of a recommendation made to General Crowder by Surgeon General Rupert Blue of the U. S. Public Health

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formation is presented in simple form and has been approved by the highest medical authorities. At the end is a striking quotation from President Wilson, "It is not an Army we must shape and train for war; it is a Nation." This is followed by the following personal appeals:

"Do not go through life with handicaps that may be easily removed. Do not shorten your life, reduce your earning capacity and capacity for enjoying life, by neglecting your bodily condition."

"While other men are cheerfully facing death for the cause of democracy, do not shrink from facing a little trouble and expense to make yourself strong, health and fit."

Over a million copies of the leaflet have been sent out to the draft boards. Requests for specimen copies should be addressed to the U. S. Public Health Service, Washington, D. C.

CHICAGO AND OTHER CITIES

Our annual comparative statement of mortality of Chicago and other cities of over a half million inhabitants for 1917, presented in this issue of *The Bulletin*, is based on the revised mortality figures

furnished by the various Departments of Health. The population estimates were furnished by the U. S. Bureau of the Census. No allowance was made for changes in population due to the war and it may be assumed that all the cities have been effected proportionately.

The general death rate and the pneumonia death rate of Chicago were the lowest of all the cities, except New York and Los Angeles. Chicago had the lowest typhoid and tuberculosis death rates of all the cities, its typhoid rate being 41 per cent lower than that of Boston, which was next in the scale. The scarlet fever death rate of Chicago was the highest of all the cities and its diphtheria rate was exceeded only by Detroit.

Compared with the similar statement for 1916, Los Angeles is the only city that showed increases in each disease. Detroit also showed more increases than decreases, indicating the probability that the population of both cities is underestimated. The typhoid and scarlet fever rates decreased in five cities and increased in five. Diphtheria rates increased in all, except New York and Baltimore. Pneumonia rates increased in all, except Philadelphia and Boston.—*Bulletin Chicago Department of Health.*

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(Continued on page 37)



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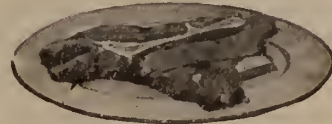
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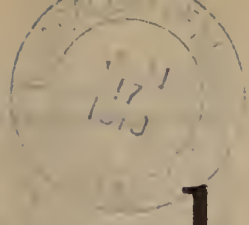
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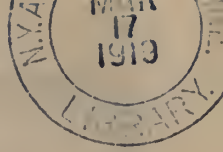
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